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The Edinburgh Royal Maternity Hospital and The Medicalisation of Childbirth in Edinburgh, 1844-1914:

A Casebook-Centred Perspective

Alison M. Nuttall

Doctor of Philosophy

The University of Edinburgh

2002

Declaration

This thesis has been composed by me and is my own work.

It has not been submitted for any other degree or professional qualification.

A small fraction of the material presented in Chapter 5 (covering midwives only, in 1850 and 1870 only) has been published in the International History of Nursing Journal.

Alison M. Nuttall

1 October 2002

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Acknowledgements

I owe a debt of gratitude to a great many people who have encouraged me with this project, including the staffs of the Centre for Continuing Education and the Scottish History Department, who, long ago, started me on this process, the members of the Edinburgh History of Medicine Group, and of the Wellcome Unit for History of Medicine.

I should also like to thank the staff of the many libraries and archives I have visited for their generous and expert assistance, in particular those of the Lothian Health Services Archive. I am also grateful to my family for their tolerance towards this fifth, most demanding 'baby', and especially to my husband for all his IT support.

Above all, I should like to thank my supervisors, Professor Roger Davidson and Dr Mike Barfoot, for their patience, guidance, support and encouragement.

Abbreviations

AHFB	Dr Barbour's quarter.
ARERMH	ERMH Annual Report.
ARS	Professor Alexander Simpson's quarter.
ARS2	Professor Alexander Simpson's second quarter.
BBA	A case when the baby was born before the arrival of either the dispensary staff at the home, or the mother at the hospital.
BMJ	British Medical Journal.
BRERMH	ERMH Birth Register.
CEU	Dr Underhill's quarter.
CMB	The Central Midwives Board.
CMBS	The Central Midwives Board for Scotland.
DBH	Dr Berry Hart's quarter.
DMERMH	ERMH Directors' Minutes.
ECA	Edinburgh City Archives.
ELII	Edinburgh Lying-in Institution.
EMJ	Edinburgh Medical Journal.
EMMS	Edinburgh Medical Missionary Society.
EOS	Edinburgh Obstetrical Society.
ERMH	Edinburgh Royal Maternity Hospital.
FWNH	Dr Haultain's quarter.
GRO	General Record Office.
ICB	Indoor Casebook.
JHC	Dr/Professor Halliday Croom's quarter.
JWB	Dr Ballantyne's quarter.
LHSA	Lothian Health Services Archive.
LPMD	London and Provincial Medical Directory.
MBMERMH	ERMH Medical Board Minutes.
OCB	Outdoor Casebook.
P.P.	Parliamentary Papers.
RCPE	Royal College of Physicians of Edinburgh.
RGS	Registrar-General for Scotland.
SECB	Students' External Casebook.
SECB(LB)	Students' External Casebook (Leith Branch).
SOCB	Special & Ordinary Casebook.

Explanation of Terms

Accidental Haemorrhage
Bleeding from a normally-positioned placental site, before delivery

Albuminuria
Nineteenth-century term for proteinuria.

'Annsarca' / 'Anasarca'
From the usage in ERMH texts, oedema.

Catamenia
Menstruation.

Chorea Gravidarum
Jerky, inco-ordinate movements in pregnancy, often associated with infection, rheumatism, or pre-existing cardiac disease, which is usually the cause of death.

Clinique
A class, or demonstration to students, focused upon one patient, possibly taking place at the bed-side.

Craniotomy
Destruction of the fetal skull to make delivery possible.

Credé's Manoeuvre
Delivery of the placenta by squeezing the uterus and applying fundal pressure.

Dispensary
Used with lower-case 'd' to be synonymous with the ERMH Outdoor provision, although in the early years the ERMH also provided a Dispensary for non-pregnant women and small children.

Dyspnoea
Breathlessness, difficult or laboured breathing.

Eclampsia
A disease peculiar to pregnancy, involving high blood pressure, proteinuria (called albuminuria in the nineteenth century), and oedema, leading to fitting, potential brain damage and death.

'Flooding'
Haemorrhage.

Grand multiparity / para / ae
Bearing a sixth or subsequent child.

Howdie
Scots term for a midwife.

Indoor
Referring to in-patients at the ERMH, whose cases were recorded in the Indoor Casebooks.

Involution
The shrinkage of the uterus after childbirth.

Lochia
Vaginal discharge following delivery and in the puerperium.

Meconium
The discharge from the bowel of a new-born infant. When mixed with the liquor (amniotic fluid) before birth, used as an indicator of potential fetal distress.

Mitral Incompetence
Leaking mitral valve in the heart (probably the result of earlier illness).

Moulding
The compression of the fetal skull that occurs during passage through the pelvis.

Neonatal
Occurring in the first month of life.

Outdoor / District
Referring to out-patients at the ERMH, who were delivered in their own homes, and whose cases were recorded in the Outdoor and Students' External Casebooks.

Parity/Parous
The number of children borne, or relating to this.

Perinatal
Occurring either slightly before or slightly after the time of birth.

Phthisis
Pulmonary Tuberculosis.

Placenta Praevia / Placental presentation
When the placenta is attached in the lower uterine segment, leading to inevitable haemorrhage.

Podalic Version
Turning the fetus to deliver as a breech presentation, by grasping one or both feet, and drawing them through the cervix.

Postmaturity

When the baby is more than 2 weeks overdue (assuming that an expected date of delivery is known and accurate).

Presentation / Presenting Part

The part of the fetus which first enters the pelvic brim and can be felt on vaginal examination. Described as vertex, face, brow (all cephalic), breech, or shoulder.

Preternatural

Term applied in the nineteenth century to labours in which the presentation is breech, brow or face, or to a multiple pregnancy.

Primigravida

Pregnant for the first time.

Primipara/ae

Giving birth to (or carrying near to term) a first child - therefore can differ from primigravida.

Pubiotomy

Temporarily opening the symphysis pubis to increase the size of the pelvis and make vaginal delivery possible.

Puerperium / Puerperal

Period immediately following childbirth, until involution is complete, or pertaining to this.

Quickening

When the mother first feels the movements of the fetus.

Singleton

One fetus in utero.

Stages of Labour

First stage: from onset to full dilatation of the cervix; second stage: from full dilatation to complete delivery of the baby; third stage: from complete delivery of the baby to complete delivery of the placenta (and, in practical terms, when any associated bleeding is controlled).

Transverse Lie

Shoulder presentation or a `cross-birth`.

Venesection

`Bleeding`: opening a vein to reduce blood volume.

Abstract

This thesis examines the development of the Edinburgh Royal Maternity Hospital in the context of medical care in Edinburgh during the period 1844-1914. It is based primarily on casebooks of the hospital and, in particular, on in-depth micro-studies of all of the hospital's Indoor and Outdoor cases in four discrete years, at approximately 20-year intervals. The central argument of the thesis is that over the period 1844-1914, professionals and patients at the hospital came to understand birth as a medical rather than a social event, and that this had repercussions for both groups as well as the institution itself.

Chapter 1 places the thesis in the context of other secondary work on the development of maternity hospitals and care, and examines the use of casebooks as primary sources. Chapter 2 considers the hospital and its staff in relation to the city and the Edinburgh medical community in particular. Chapter 3 examines the patients who attended. It argues that, in the nineteenth century, their perception of the hospital was as a place of social shelter. However, by 1912 a greater number attended for otherwise unaffordable medical care at birth. Chapter 4 examines the medical treatment given to patients. It argues that there was increasing acceptance of medicalisation by patients in the period studied, and increasing confidence in giving such treatment by the professionals involved. Chapter 5 discusses the staff and male and female trainees at the hospital. It suggests that, prior to the introduction of national requirements, the provision of training was driven by commercial concerns, and therefore varied throughout the period studied, particularly in the amount of practical experience offered. The relationship between the different grades of staff and the treatment they offered, described in the chapter, suggests increasing stratification in the roles of doctors and nurses at delivery and during the puerperium. The increase in nursing care following the birth indicates the creation of a professional role that among the poor had previously been undertaken by family members. The role played by increasing anxiety over infection following the introduction of strict antiseptic measures is discussed.

The thesis concludes that in Edinburgh the medicalisation of childbirth among the poor was well-advanced by 1912, and suggests that this was a result of increasing patient acceptance combined with the increasing professionalisation of care.

Chapter 1

Introduction

1.1 Historiography

In general, maternity hospitals have not been a popular subject for historical study in Britain, although they now provide maternity care for the majority of the pregnant population, and hence much clinical experience for trainees and staff. Such studies of maternity hospitals as there have been, have tended to be histories of individual, older institutions, often based on the administration records of the hospital in question.[1] There are a number of weaknesses in such histories. Firstly, they tend to see the institution in isolation, without a comparative perspective. Thus descriptions of changes are unrelated to practice elsewhere, and the opportunity to examine differing advances in maternity care is lost. Secondly, the authors, frequently senior doctors at the institution, tend to present only a medical point of view. Further, they adopt a Whig-historical approach to maternity care and midwifery, presenting the medical developments at the hospital as a heroic story of constant progress. Finally, this focus on medical progress means that the greater part of their story is based in the twentieth century, largely ignoring the earlier charitable function of their chosen institution. With the exception of a general and little-known survey of British maternity hospitals, made in 1964 by Alistair Gunn, there has been little analysis of the work of such institutions as a whole.[2]

Outwith Britain, a large number of maternity hospitals have been examined in detail, using a much wider range of sources, including casebooks and admission registers. In Dublin, Ian Campbell Ross has examined the foundation of the Rotunda. A

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[1] For example, see Philip Rhodes *Doctor Leake's Hospital – a History of the General Lying-In Hospital, York Road, Lambeth 1765-1971* (London: Davis Poynter Ltd., 1977); Sir John Dewhurst, 'A Short History of Queen Charlotte's Hospital', *Journal of Obstetrics & Gynaecology*, 10 (1990), pp. 229-32; Derek A. Dow *The Rottenrow* (Carnforth: the Parthenon Press, 1984).

[2] Alistair Gunn, 'Maternity Hospitals', in F. N. L. Poynter (ed.), *The Evolution of Hospitals in Britain* (London: Pitman Publishing, 1964), pp. 77-101. This survey was based mainly on previously-

number of themes have arisen from this, including the place of the hospital both in society (as part of the development of a protestant charitable structure) and in the history of midwifery.[3] In New York, Virginia Quiroga has studied in detail the New York Asylum for Lying-in Women, and the Midwifery Dispensary and Lying-in Hospital, arguing that over time the understanding of an institution's function by staff and patients changed, and that patients' response to an institution played a part in its evolution. However, she too notes the association between changes in medical education and the expansion of hospital care.[4] In Germany, Jürgen Schlumbohm has suggested that the Lying-in Hospital of the University of Göttingen was developed by Osiander to provide clinical experience, although his analysis suggests that the patients manipulated the system, and saw the hospital as providing shelter rather than treatment.[5] In Australia, Janet McCalman has studied the Royal Women's Hospital, Melbourne. This study perhaps has most relevance to the Edinburgh Royal Maternity Hospital [ERMH], since its founders believed that they were creating a maternity hospital according to Simpson's ideal. McCalman sees the hospital from its beginning as primarily a medical establishment, and, unusually, recognises its dispensary ('outdoor') work, although surviving evidence for this is from the twentieth century. By this, and by linking its records of maternal and infant health with the economic state of Melbourne at the time, she places her study of the hospital in its wider community. Nonetheless, she maintains an overall belief in the significant contribution of the hospital to the health of the city through its development of maternity care.[6]

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published histories, and concluded that the establishment of maternity hospitals in Britain was directly associated with the need for clinical education.

[3] Ian Campbell Ross, 'The Early Years of the Dublin Lying-in Hospital', and 'Midwifery' in Ian Campbell Ross (ed.) *Public Virtue, Public Love: The Early Years of the Dublin Lying-in Hospital – the Rotunda* (Dublin: the O'Brien Press, 1986), pp. 9-52, 125-64.

[4] Virginia Anne Metaxas Quiroga, 'Poor Mothers and Babies: a Social History of Childbirth and Childcare Institutions in Nineteenth Century New York City' (State University of New York at Stony Brook, Ph.D. Thesis, 1984).

[5] Jürgen Schlumbohm, ' "The Pregnant Women are Here for the Sake of the Teaching Institution": the Lying-In Hospital of Göttingen University, 1751-c.1830', *Social History of Medicine*, 14, No. 1 (2001), pp. 59-78.

[6] Janet McCalman *Sex and Suffering – Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856-1996* (Melbourne: Melbourne University Press, 1998).

This summary of overseas writing on maternity hospitals raises the question of why there should be less analysis of their role in Britain, for which there are a number of possible answers. In the late nineteenth and early twentieth century, in-patient provision was extremely small. However attended, the patient's home was the place for childbirth. Nineteenth-century obstetricians (and others) were at best equivocal about the creation or defence of maternity hospitals, a result of existing hospitals' grim reputation in terms of infection, and the assumed immoral nature of their inmates. Thus there were only a small number of in-patients in the nineteenth and early twentieth century and these were atypical of the child-bearing population. The role of maternity hospitals is therefore perceived as tangential in any work taking a thematic view of maternity care in the nineteenth and early twentieth century.

However, three recent English studies have included an examination of the broader social role of the local maternity hospital. Lara Marks has incorporated examination of the work of the Jewish Maternity Home and the London Hospital in her study of motherhood among the immigrant Jewish population, particularly in the East End of London, during the late nineteenth and early twentieth century.[7] Maxine Rhodes has used local government material from Kingston-upon-Hull to analyse the expanding municipal provision of maternity care in that city from 1900 to 1939, including in this an analysis of the increasing use made of the Hull Municipal Maternity Home.[8] Tania McIntosh has written a detailed local study of maternity care in Sheffield from 1879 to 1939, including examination of the unique midwifery training and dispensary associated with the Jessop Hospital for Women.[9]

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[7] Lara Marks *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939* (Oxford: Clarendon Press, 1994); Lara Marks, 'Mothers, Babies, and Hospitals: "The London" and the Provision of Maternity Care in East London, 1870-1939', in Valerie Fildes, Lara Marks, and Hilary Marland (eds) *Women and Children First: International and Maternal and Infant Welfare, 1870-1945* (London: Routledge, 1992), pp. 48-73.

[8] Maxine Rhodes, 'Municipal Maternity Services: Policy and Provision 1900-1939 with Particular Reference to Kingston-upon-Hull and its Municipal Maternity Home' (Hull University Ph.D. Thesis, 1996).

[9] Tania McIntosh, ' "A Price Must Be Paid for Motherhood": the Experience of Maternity in Sheffield, 1879-1939' (Sheffield University Ph.D. Thesis, 1997); Tania McIntosh, 'Professional Skill or Domestic Duty? Midwifery in Sheffield, 1881-1936', *Social History of Medicine*, 11 (1998), pp. 403-20.

In each case the hospital has been seen as part of a larger picture of expanding maternity care in a local area. The treatment given to pregnant women, particularly in the early twentieth century, has been a major focus of women's history, but the principal interest has been the significance and nature of increasing state provision and supervision. For example, Jane Lewis has used government papers and Women's Co-operative Guild material to examine the introduction of maternity care by local and central government. She interprets this as increasing state intervention to reduce the physical effects of poverty on the nation's greatest future resource, its children: its concern for women being limited to their role as nurturers.[10] Whilst reference is made to earlier philanthropic actions such as charitable dispensaries, these are seen as small-scale compared to the national and local government actions they stimulated. However, Marks, McIntosh and Rhodes note that in reality much maternal and child welfare was provided by a combination of local government and charitable provision, McIntosh particularly pointing out that local schemes were seldom a direct precursor of the National Health Service.

The historiography of maternity hospitals also overlaps with the much larger historiography relating to midwifery.[11] Much of this vast literature relates to the introduction of midwifery registration and the passing of the first (1902) Midwives (England and Wales) Act.[12] However, as the historiographical midwifery debate has

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[10] Jane Lewis *The Politics of Motherhood* (London: Croom Helm, 1980). However, for a description of twentieth-century charitable intervention, see A. Susan Williams' history of the National Birthday Trust. (A. Susan Williams *Women and Childbirth in the Twentieth Century* (Stroud: Sutton Publishing, 1997).

[11] For an in-depth examination of midwifery-related literature, see Alison M. Nuttall, 'Change and Continuity in the Training of Midwives in Nineteenth Century Edinburgh' (University of Edinburgh MSc. Thesis, 1997).

[12] For the registration debate, see, for example, Betty Cowell and David Wainwright *Behind the Blue Door: the History of the Royal College of Midwives 1881-1981* (London: Baillière Tindall, 1981), for feminist contrast, Jean Donnison *Midwives and Medical Men: a History of the Struggle for the Control of Childbirth* (London: Historical Publications (2nd edn), 1988), and, for an alternative professionalising interpretation, Brooke Victoria Heagerty, 'Class, Gender and Professionalization: the Struggle for British Midwifery 1900-36' (Michigan State University, Ph.D. Thesis, 1990) and Bob Little, ' "Go seek Mrs Dawson – she'll know what to do" – the Demise of the Working-Class Nurse/Midwife in the Early Twentieth Century' (University of Essex, M.A. Thesis, 1983). However, the unity of purpose in the Central Midwives Board in ending working-class midwifery practice implied by Heagerty and Little is questioned by June Hannam, in 'Rosalind Paget: the midwife, the women's movement and reform before 1914', in Hilary Marland and Anne Marie Rafferty (eds) *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period* (London: Routledge, 1997), pp. 102-33.

moved from this towards an examination of the professional implications of increasing national and local government interest in the welfare of mothers and infants. two aspects in particular provide additional perspectives and contribute to the study of maternity care. Firstly. the extent of regional variation in maternity provision has become more apparent. This has led to a number of regional studies of maternity care in England.[13] Secondly. while these studies are primarily focused on the early twentieth century. they suggest that the initial chronology of the development of maternity care associated with the registration debate was too simplistic. and show that there were a number of effective. if local. initiatives in the nineteenth century. In addition. by abandoning a state-orientated approach in favour of examining local government and charitable action. they suggest that the registration campaigners' blanket criticism of nineteenth century midwifery was too harsh.[14]

However. until recently there has been much less interest in local studies in Scotland. and indeed. much less work on midwifery and maternity care there overall. In 1963. Jean Ferlie. sometime-Matron of the ERMH and then President of the Royal College of Midwives. wrote a historical survey of midwifery in Scotland. unsurprisingly focusing on the creation of a separate profession in the early twentieth century.[15] Although she drew attention to the early role of Edinburgh in midwifery education for both sexes. influenced by writing at a period of increasing state provision. and when the mainstream history of the British Isles was seen as unionist. she presented

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[13] See. for example. and in addition to the works by Marks. McIntosh and Rhodes previously cited. Joan Mottram. 'State Control in Local Context: Public Health and Midwife Regulation in Manchester. 1900-1914'. in Marland and Rafferty (eds). *Midwives. Society and Childbirth*. pp. 134-52. and Elizabeth Peretz. 'A Maternity Service for England and Wales: Local Authority Maternity Care in the Inter-War Period in Oxfordshire and Tottenham' in Jo Garcia. Robert Kilpatrick and Martin Richards (eds) *The Politics of Maternity Care* (Oxford: Clarendon Press. 1990). pp. 30-46. These may also have been partly driven by an appeal for local studies in medicine made by J. V. Pickstone. who feels that by narrowing the geographical area. such studies make an in-depth examination of the inter-play between various medical fields and local society possible (J. V. Pickstone. 'Medicine in Industrial Britain: the Uses of Local Studies'. *Social History of Medicine*. 2 (1989). pp. 197-203).

[14] See. for example. Mottram. 'State Control in Local Context'. Maxine Rhodes. Municipal Maternity Services. and McIntosh. 'Professional Skill or Domestic Duty?'. whilst Seligman's study of the Royal Maternity Charity in the early nineteenth century makes a similar point. (Stanley A. Seligman. 'The Royal Maternity Charity: the First Hundred Years'. *Medical History*. 24 (1980). pp. 403-18).

[15] Jean Ferlie. 'A Historical Survey of Midwifery in Scotland'. *International Journal of Nursing Studies*. 1. (1963-4). pp. 125-9.

midwifery development in Scotland as parallel to that in England. In doing this, her conclusion that there was little midwifery training in Scotland in the nineteenth century is at odds with the evidence of good-quality midwifery training in Glasgow given to the 1892 Committee on Midwives' Registration.[16] In 1974, H. P. Tait, the last Medical Officer of Health for Edinburgh, published a history of the work of his department, which included an examination of the provision of group maternity care in Edinburgh. For him, this started with the council-sponsored Edinburgh Maternity Scheme in 1917, and thus again focused on twentieth-century developments. He largely ignored the role of charitable organisations in the city.[17]

In contrast to Tait's focus on local government provision, in 1997 Barbara Mortimer published an analysis of the independent practice of nineteenth-century monthly nurses in the city, some of whom acted as both nurses and midwives. She concluded that, in contrast to later criticism of monthly nurses by the Central Midwives Board, these women perceived themselves to be professionals who capitalised on the medical and social contacts that they made both whilst training and working.[18] This theme has been extended in her 2002 thesis.[19] In this, examining all nursing care in Edinburgh in terms of professionalisation, she concludes that, with regard to maternity care, the mid-nineteenth century saw the virtual end of the traditional midwife in Edinburgh, as a result of the local expansion of the medical profession. Having examined in detail the careers and potentially professionalising actions of all the independent nurses recorded in two censuses, the main thrust of the thesis discusses their later denigration and replacement by those trained in hospitals

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[16] Bizarrely, this was provided by one of the bitterest medical opponents of midwifery in general, and of registration in particular, Dr Robert Rentoul. (Parliamentary Papers, [P.P.], *Report of the Select Committee on Midwives' Registration*, 1892 (289) XIV, pp. 1-173, Evidence of R. R. Rentoul M.D., q:378).

[17] H. P. Tait *A Doctor and two Policemen* (Edinburgh: Mackenzie and Storrie Ltd., 1974). By 1917 charities such as the ERMH and its associated dispensaries already provided maternity care for approximately 30% of Edinburgh births.

[18] Barbara Mortimer, 'Independent Women: Domiciliary Nurses in Mid-Nineteenth-Century Edinburgh', in Anne Marie Rafferty, Jane Robinson and Ruth Elkan (eds) *Nursing History and the Politics of Welfare* (London: Routledge, 1997), pp. 133-49.

[19] Barbara E. Mortimer, 'The Nurse in Edinburgh c.1760-1860: The Impact of Commerce and Professionalisation' (Ph.D. Thesis, University of Edinburgh, 2002).

following the reforms of Florence Nightingale, whose primary loyalty lay, not with their patient, but with the medical attendants involved.

In addition, Lindsay Reid has published a mainly un-annotated series of oral accounts of midwifery in twentieth-century Scotland, which indicates that monthly nursing by both trained and untrained women continued into the 1940s, particularly in rural areas.[20] As a whole, these testimonies emphasise the great changes that maternity care in Scotland has undergone in the twentieth century, although the significance of individual comments is not discussed, except by the informant herself.

It is also apparent from the works of Marks, Rhodes and McIntosh that hospital material can provide evidence for the professionalisation of maternity care. Rhodes, in particular, has been able to examine in detail the training, employment and experience of midwives at the Hull Municipal Maternity Home, and compare this with those in independent or municipal practice in the town, and with other childcare professionals. McIntosh has supplemented Hospital Minutes with Post Office Directories, the Census, and newspaper reports to examine the slow move to professionalisation in Sheffield. However, with these exceptions, hospital evidence for midwifery professionalisation has not been much examined in Britain. The focus of the Midwives' Institute was on improving maternity care in the home, and not on improving maternity hospitals, whilst, in contrast to nursing, its certification, and not the reputation of an individual training institution, was to be the key to independent practice. This, combined with the short length of training, prevented the development of a close association between midwives and the 'parent' hospital.[21] Thus maternity hospitals in Britain have been seen to contribute comparatively little to professionalisation, in contrast to the midwife training school at Heerlen, described

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[20] Lindsay Reid *Scottish Midwives: Twentieth Century Voices* (East Linton: Tuckwell Press, 2000).
[21] Rhodes believes the short length of training, and its wide-ranging and shallow curriculum, was deliberate policy on the part of the Central Midwives Board (whose membership was not required to include a midwife) to prevent professionalisation. (Maxine Rhodes, 'Municipal Maternity Services', p.125).

by Hilary Marland.[22] Further, much midwifery history has been written, if not necessarily by midwives, or from a feminist point of view, nonetheless from a position that admires the initial emphasis on independent practice of the Midwives' Institute, that equates midwifery with home confinement, and that believes much midwifery knowledge and independence has been lost through the steady rise in hospital confinement.[23] Thus the hospital is seen as a place where midwifery skills are reduced and professional identity lost, and, crucially, there is less personal contact with patients. However, by examining training, career opportunities, and treatments offered by hospitals, the role of the hospital in midwives' professional lives can be seen to be more complex.[24]

Recent research also indicates that hospital material can provide evidence of the increasing medicalisation of childbirth, that is, the process by which medical priorities come to dominate those of the patient and her family and in which birth is seen primarily as a medical and not a social event. This process, seen to commence with the development of man-midwifery in the eighteenth century, has been analysed from a variety of viewpoints. Both Jean Donnison, and Carter and Duriez adopt a feminist stance, seeing male doctors muscling in on a female occupation to their professional benefit, depriving one group of women of their livelihood, and another of their right to an intervention-free birth.[25] However, it is a weakness of this feminist approach that it ignores the role of patient choice. Wilson, Shorter, and

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[22] Hilary Marland, 'The Midwife as Health Missionary: the Reform of Dutch Childbirth in the Early Twentieth Century', in Marland and Rafferty (eds), *Midwives, Society and Childbirth*, pp. 153-79.
[23] See, for example, Nicky Leap and Billie Hunter *The Midwife's Tale* (London: Scarlet Press, 1993) and Sheila Hunt and Anthea Symonds *The Social Meaning of Midwifery* (London: Macmillan Press, 1995). In addition, strongly feminist writers, such as Margaret Connor Versluysen, have interpreted the maternity hospital as a place of male dominance over both women and birth (Margaret Connor Versluysen, 'Midwives, Medical Men and 'Poor Women Labouring of Child': Lying-in Hospitals in Eighteenth Century London', in Helen Roberts (ed.) *Women, Health and Reproduction* (London: Routledge and Kegan Paul, 1981), pp. 18-49), whilst Ann Oakley believes that their twentieth-century expansion of function indicates increasing male medical control of women. (Ann Oakley *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell Publishers Ltd., 1984)).
[24] Rhodes points out the large number of 'medical' treatments, including delivering malpresentation cases sent in by GPs in expectation of a medical delivery, and manual removal of placenta, carried out by senior midwives at Hull Municipal Maternity Home, ostensibly to reduce the doctor's workload. (Maxine Rhodes, 'Municipal Maternity Services', p. 230).
[25] Donnison, *Midwives and Medical Men*; Jenny Carter and Therese Duriez *With Child: Birth through the Ages* (Edinburgh: Mainstream, 1986).

Gélis have also used contemporary medical writing, plus, in the case of Gélis, recorded folklore from the seventeenth to the twentieth century, to examine increasing medical involvement in birth, and conclude that medicalisation indicates a different intellectual approach to birth on the part of the consumers.[26] Charlotte Borst also discusses the role of changing perceptions of childbirth and its risks by patients in her examination of the decline in use of midwives in late nineteenth-century Wisconsin, whilst in Denmark Anne Løkke examines the changing nature of the midwife's role, from social to medical, at much the same time.[27]

It is evident that whilst childbirth was often a source of professional rivalry, and that it did become an increased cause for government concern, by 1900 it was already undergoing change through the altered desires of patients. Both Rhodes and McIntosh have interpreted this as an increasing use of hospital confinement, and Rhodes has analysed the patients of the Hull Municipal Maternity Home for their motives in seeking admission, believing that an increasing number had no medical reason to do so. From her analysis of their treatment, she also notes that they were misled if they believed they would have close medical supervision as a result of their choice.[28]

However, whilst Marks refers to the creation of two large dispensaries by the London Hospital, one staffed by medical students, and the other by pupil midwives, and comments on the gruelling number of cases attended by the students, as the result of the small amount of in-patient provision before 1918,[29] and Tania McIntosh notes that midwives were trained by the Jessop Hospital from 1879 expressly to work in its

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[26] Adrian Wilson *The Making of Man-Midwifery: Childbirth in England 1660-1770* (London: UCL Press, 1995); Edward Shorter, 'The Management of Normal Deliveries and the Generation of William Hunter', in W. F. Bynum and Roy Porter (eds) *William Hunter and the Eighteenth Century Medical World* (Cambridge: Cambridge University Press, 1985), pp. 371-83; Jacques Gélis *History of Childbirth: Fertility, Pregnancy and Birth in Early Modern Europe* (Cambridge: Polity Press, 1991 (in translation)).

[27] Charlotte G. Borst *Catching Babies: the Professionalisation of Childbirth, 1870-1920* (Cambridge, Mass.: Harvard University Press, 1995); Anne Løkke, 'The "Antiseptic" Transformation of Danish Midwives, 1860-1920', in Marland and Rafferty (eds), *Midwives, Society and Childbirth*, pp. 102-33. Similar comments on changing attitudes to childbirth are made by Maxine Rhodes, 'Municipal Maternity Services', pp.4-5, and McIntosh, ' "A Price Must Be Paid for Motherhood" ', pp. 150-1.

[28] Maxine Rhodes, 'Municipal Maternity Services', p. 220-30.

[29] Lara Marks, 'Mothers, Babies, and Hospitals', pp. 58-64.

Dispensary,[30] the role of dispensaries in delivering and educating poor mothers has not been not examined in detail, possibly due to a lack of detailed sources. Nonetheless, the analysis of the expansion of dispensaries in cities in the late nineteenth century can contribute both to debates about the training and increasing professionalisation of midwifery, and about the increasing medicalisation of childbirth.

It is evident from the above sources that the late nineteenth and early twentieth century was a period of change in approaches to childbirth, in which, throughout British society, it came to be seen primarily as a medical and not a social event. This can be seen not only in the development of recognised professional attendance, but also in the interpretation and attitude taken to birth by the patients. Their increasing willingness to seek out and have medical attendance, male or female, as indicated by the increase in dispensaries, weakens feminist interpretations of medicalisation as being the result solely of increasing male domination.

However, perhaps because of their small number of in-patients and the difficulty of accessing their outdoor patients, there has been little use of maternity hospital material as a means of examining this increase in medicalisation. Nonetheless, they are associated with both midwifery and medical education in childbirth, and, as such, a major influence on midwifery practice. Their assumptions about care, however these are derived, and their need for training cases and for the supervision of pupils, have all led to a more structured approach to birth. In addition, their development of associated dispensaries provided trainees with formative experiences of home delivery and care with minimal supervision, but within a hospital framework. Thus it can be suggested that the developing administrative needs and medical protocols of maternity hospitals have contributed to the medicalisation of childbirth, and deserve further examination. Hospital material can also provide the means of seeing changes that occurred in midwifery and childbirth practice (for example, bedrest, perineal repair, increasing nursing function), in relation to changes in the overall medical approach to childbirth. This suggests there is a need to study the world of the late-

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[30] McIntosh, 'Professional Skill or Domestic Duty?', pp. 405-7.

nineteenth and early twentieth maternity hospital, its indoor and outdoor practice, in detail.

1.2 Aims

The aim of this thesis is therefore to examine in detail aspects of the development of a maternity hospital and its dispensary services during the second half of the nineteenth century and early twentieth century. This can appear to be a retrograde step: as has been shown, other recent studies have embedded the hospital within a wider picture of maternity care. However, there are several differences that make this a reasonable approach. This study starts in detail in 1850, some 50 years before the introduction of any national child welfare strategy. Whilst there were other dispensaries in Edinburgh which provided lying-in services, the number of births they handled was much smaller, and, with the exception of those of the Hospice (opened in 1903), no completed casebooks from the period have survived.[31] In addition, any evidence of privately-attended births, which were the great majority, comes only by chance. Further, the intention is to examine evidence of changes in approach to childbirth in the hospital and its dispensaries - that is, its increasing medicalisation - and in the education and professional development of the staff involved, seeing how this is linked to the hospital's growth. This has been done by making four micro-studies at approximately twenty-year intervals, which provide fine detail of actual life within the hospital and dispensary during a period of great social change, but require considerable internal linkage.

The ERMH offers a rich opportunity for this: whilst it was officially established in 1844 it had roots in the eighteenth century, and, despite four name changes, continues to the present day. Although it was associated with James Young Simpson, the most newsworthy obstetrician of his time, in the mid-nineteenth century it was a small charity offering Indoor and Outdoor care to applicants and training for male and female pupils. By the early twentieth century, it was considered to be an important maternity hospital. This was partly through its association with Simpson,

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[31] That of the Edinburgh Lying-In Institution survives, but no cases were recorded between approximately 1840 and 1903, although the charity apparently continued to operate.

but much more through the expansion of the Edinburgh medical schools, and the teaching and research reputation of Halliday Croom and his contemporaries. It had a Central Midwives Board-approved midwifery training school, and also offered midwifery experience to medical students through associated dispensaries, and to junior doctors as house surgeons. Thus, potentially, the ERMH could provide evidence of changing hospital and dispensary midwifery practice from the mid-nineteenth century, and this is in fact feasible, owing to the continued survival of a diverse range of hospital papers, casebooks, minutes, and registers.

Material from the ERMH archive has been used previously. In 1937, when the hospital was on the point of absorption into the Royal Infirmary, Douglas Miller summarised its history as his own farewell address to the Edinburgh Obstetrical Society.[32] He used principally his own long service, but also hospital administration records, to focus on the expansion and development after World War I, whilst playing down the hospital's earlier history, and completely failing to mention any nursing staff. John Sturrock, also a senior doctor at the hospital, has examined its early history and previous sites, as well as its place in medical history, using principally the hospital's administration papers to do so.[33] W. Peter Ward has used data on baby weights, maternal origins, marital status and occupation, taken from the Indoor casebooks and Births Registers, as indicators of economic decline in Edinburgh, part of a larger study of a number of major cities in Europe and America.[34] Irvine Loudon has also used illustrative material from the Special and Ordinary casebooks, which principally record complicated case histories.[35] However, ERMH papers have not been used before to create a picture of the changing role of the maternity hospital itself in the nineteenth and early twentieth century, in the

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[32] Douglas Miller, 'Valedictory Address: A Short Record of the Edinburgh Royal Maternity and Simpson Memorial Hospital', *Transactions of the Edinburgh Obstetrical Society*, XCVII (1937-8), pp.1-12.

[33] John Sturrock, 'Early Maternity Hospitals in Edinburgh (1756-1879)', *Journal of Obstetrics and Gynaecology of the British Empire*, LXV (1958), pp. 122-31; John Sturrock, 'The Edinburgh Royal Maternity and Simpson Memorial Hospital', *Journal of the Royal College of Surgeons of Edinburgh*, 25 (May 1980), pp. 173-87.

[34] W. Peter Ward *Birth Weight and Economic Growth: Women's Living Standards in the Industrializing West* (Chicago: University of Chicago Press, 1993).

[35] Irvine Loudon *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality 1800-1950* (Oxford: Clarendon Press, 1992), pp. 98-9.

increasingly medical approach to birth, and in the development of the specialist professions associated with birth, which is the purpose of this thesis.

Three main themes have been examined directly from the hospital data. In Chapter 3 it is argued that the changing attitude to the hospital shown by the patients indicates that they perceived a change in its function, from a social shelter to the source of skilled medical treatment, but that this only occurred in the early twentieth century. In Chapter 4 the treatment given is examined. It is demonstrated that this also changed, by adopting surgical techniques and developing a more pro-active approach, although its immediate effectiveness, particularly in complicated cases, can be doubted. It is argued that this change largely resulted from increasing medical professional confidence in applying pre-existing technology. However, the greatest change introduced by the ERMH, which contributed most to the medicalisation of childbirth, was the provision of routine professional care to all patients postnatally. Chapter 5 examines the close association between the hospital and education in midwifery. It has been argued that maternity hospitals developed as a response to increased demand for training places for midwives and medical students. Whilst similar pressures applied in Edinburgh, it is suggested that the overall picture was more complex, and that the ERMH not only provided training places for students, but encouraged the professional specialisation of obstetricians by providing an arena in which senior doctors, already primarily noted for their lecturing ability, could demonstrate their clinical skills.

1.3 Source Critique

This examination of the development and changing role of the ERMH in the provision of maternity care to the poor in nineteenth and early-twentieth century Edinburgh, is based principally on its own papers. These fall into several categories and types.

1.3.1 Non-Medical Administration Papers

The Directors' Minutes have been preserved since 1856, although it can be deduced that a first volume, covering the establishment of the ERMH, is missing. For much of the period studied, these records were maintained by a semi-professional secretary,

although Dr Ballantyne acted in this role in 1908-9. Initially, the meetings of the Medical Board were also recorded here, as were those of the Ladies' Committee from its establishment in 1869 to the end of the period of study. However, from 1870 Medical Board Minutes were kept separately, one of the senior doctors acting as secretary on an apparently random basis, and Medical Board members were excluded from Directors' meetings. Barbara L. Craig has described hospital administration records as defining a chain of command and indicating a hierarchy within the hospital.[36] Records were seen as desirable by constituent groups as evidence of their official status: she sees the emergence of the medical staff as a separate record-keeping body as mirroring their increasing authority. The introduction of separate Medical Board Minutes can be interpreted similarly at the ERMH, whilst, conversely, the Ladies' Committee did not merit a separate record within the period studied. Meetings of both Boards occurred approximately quarterly. In terms of content, both sets of Minutes record attendees and subjects discussed for every meeting, although the meaning is not always immediately clear. This can be because the writer recorded the debate for his contemporaries already involved in the hospital, but possibly also results from deliberate obfuscation. For example, when Charles Bell was asked to resign as an ordinary physician in 1873, the reason is not made clear in either set of Minutes.[37] Thus, as a source they provide a good chronological record (and have been used before as such), but only in limited fields.

The ERMH also published Annual Reports to its subscribers, and these exist in an almost complete series from 1870,[38] thus providing a further chronological record. Typically these contained an account of the hospital's year, including the number of Indoor and Outdoor cases, and the mortality for the year. A report of the activities of the Ladies' Committee was also included, and often comments on new appointments, or on the nursing staff. Names of hospital staff and appointees, down to the assistant physicians, were listed. There was also a summary of the hospital's accounts. From

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[36] Barbara L. Craig, 'The Role of Records and of Record-keeping in the Development of the Modern Hospital in London, England, and Ontario, Canada, c.1890-1940', *Bulletin of the History of Medicine*, 65:3 (1991), pp. 376-97.
[37] ERMH Directors' Minutes [DMERMH], 17 April 1873, 1 July 1873; ERMH Medical Board Minutes [MBMERMH], 3 June 1873, 4 July 1873.
[38] The Annual Reports for 1874 and 1878 are missing.

1882 there were references to the use of lady collectors, and from 1900 their names were published, with the areas and sums for which they were responsible. From 1876 donations in kind were also recorded. The Annual Reports not only functioned as the hospital's principal acknowledgement and means of communication with its subscribers, but also as its public, fund-raising face. As such, the reports have a positive tone, whilst stressing the care given to those in need. This dramatisation must be borne in mind when considering them as source material. The precise authorship is unknown.

Births Registers survive from 1847, and were maintained, apparently without lapses (although an early page is missing, and pencil entries have become illegible), throughout the period studied. According to the Hospital Rules, prior to admission a potential patient would have given to the Secretary 'correct information in reference to her *age*, place of *birth*, and *parentage*, and also in reference to the various places in which she has resided ... in order to determine the parish on which she may have a claim for parochial relief. If ... married, she shall be required to give the name and residence of her husband, and ... also similar information regarding the places in which he has resided: - if unmarried, the name and residence of the child's father, and any other information regarding him which may be required.'[39] This information appears in single-line entry in the Births Register,[40] but it can be deduced that by 1877, when a new style of Births Register was introduced, these data were recorded by the Matron rather than by the secretary.[41] Less detailed social information was collected after this date: most notably the details of the baby's father were omitted if the child were illegitimate. By 1890 it is evident that the recording was done some time after admission, or possibly at discharge, as the information for patients who

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[39] *Rules and Bye-Laws of the Edinburgh Maternity Hospital* (Edinburgh: Andrew Murray, Printer, Milne Square, n.d.), 'Patients', Rule 1.

[40] In addition, patients' literacy was recorded intermittently from 1847 to 1860.

[41] From 1892, when a new matron, Miss Edward was appointed, the Register was maintained in the same hand that completed the new Register of Nurses. Prior to that date, and with the exception of occasional weeks, the Register entries are made in one script, which ages over time. Mrs Mather, the previous matron, was appointed in 1875 and resigned due to ill-health in December 1891, aged 70.

died in hospital is incomplete.[42] However, for the majority of patients the records are normally fairly complete.

From 1892, when Miss Edward became Matron, a Register of Nurses was maintained. This may reflect Miss Edward's previous experience at the Royal Infirmary, but it could also, as suggested by Craig, indicate the increasing importance attached by the hospital to the nursing department itself. The Register of Nurses offered the potential to record midwifery nurses' names, addresses, marital status and age, in 'class' order. There was a 'remarks' column which, intermittently, shows individuals' previous experience or training, the number of cases they attended at the ERMH, their future employment, and, later, examination success. However, Miss Edward preferred to write a brief assessment, possibly as an *aide-memoire* if a reference was later necessary, thus reducing the value of this source prior to 1908.[43] Thus, the information contained is more irregular than is immediately obvious. After Miss Edward retired in 1908, it is no longer clear who made the entries, but the fact that there is no change in the handwriting in Autumn 1914, when Miss Barclay was called up, suggests that by then Matron had delegated this task. Further evidence of nursing activity comes from the existence of random hospital and midwifery lecture certificates that have been gifted to the Lothian Health Services Archive. These provide confirmatory evidence only.

Initially, the hospital's quarterly accounts were included in the Directors' Minutes, but separate Cash Books survive for the period 1876-1898, although there are no routine accounts extant from 1889 to 1891. Authorship is unknown. In addition to routine domestic transactions, the Cash Books record payments from individual nurses for their time in the hospital and their board, as well as the salaries paid to the matron and head nurse, and indicate that the house surgeons dealt with the sale of

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[42] The entries for Mrs Mary Winters (1890 Indoor Casebook [ICB], case 31 (Dr Halliday Croom's quarter) [JHC] [057/31hc/90si]), died 25 October 1890, and Mrs Spence (1890 ICB, case 17 (Prof. Simpson's second quarter [ARS2] [106/17ss/90si]), died 29 November 1890, are incomplete. This comment also applies to 1912. The theory that Births Register entries were made near discharge has been further tested and confirmed by plotting the Births Register numbers for 1912 against the dates of delivery.

[43] For example, 'Beatrice Callander, soldier's widow from Perth, quiet and diffident, for work in Perth.' (ERMH Register of Nurses, August 1897 set).

hospital tickets to medical students. They also show that a few inmates paid for their care, and that some were paid for by parochial boards. Again this source provides confirmatory evidence only.

1.3.2 Clinical Records

The ERMH has a large number of surviving clinical records, some dating from its inception in 1844. These come in two main types, the registers that form the Indoor and Outdoor casebooks and Students' External casebooks, and the narrative accounts of the Special and Ordinary casebook. The former are examined first.

Completion of 'an accurate register both of the In and Out-cases' was, according to the Rules, the responsibility of the house surgeons: some were more assiduous than others.[44] There are a number of gaps in the records of Indoor deliveries during the late 1850s and 1860s, and both the variety of scripts and short asides suggest that in the earlier years, medical students entered their own Outdoor cases into that delivery record. By 1890 both these casebooks appear to have been maintained by the responsible house surgeon himself, whilst the last unexplained gap Indoors occurred in 1880. Taking the form of a double-page, single-line entry, both books had the potential to record patients' names, ages, parity, the date of delivery, classification of labour, position and presentation of the child, its state on delivery and at discharge, that of the mother on discharge, 'by whom delivered', and any pertinent remarks. Examples are given in Illustrations 1.1 to 1.4, at the end of this chapter. In addition, the Outdoor books included the address, whilst Indoors, dates of the beginning and end of the 'last catamenia' and of quickening, the lengths of the stages of labour, the weights of the child and placenta, and the lengths of child and umbilical cord, were also recorded. As sources, these casebooks present a number of problems in terms of their legibility, and in the sheer quantity of cases recorded, as well as in corroboration and plausibility. Independent corroboration of individual cases has not been found, but aspects of some cases can be confirmed through records of student experience. However, the plausibility of the records - whether all cases were included, or whether serious cases were edited out as affecting badly the hospital's

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[44] *Rules and Bye-Laws of the Edinburgh Maternity Hospital*, 'House Surgeons', Rule 2.

reputation - can be partly checked by comparing the incidence of breech and twin deliveries recorded in the four years studied in detail with figures for such cases from the pre-IVF 1970s.[45]

Table 1.1
Incidence of Twin and Breech Deliveries in the Indoor and Outdoor Practice of the ERMH in 1850, 1870, 1890, and 1912, Compared with 1970s Data

	1970s	1850 Indoor	1850 Outdoor	1870 Indoor	1870 Outdoor	1890 Indoor	1890 Outdoor	1912 Indoor	1912 Outdoor
Breech	2.5-3%	5.5%	3.4%	3.8%	4.0%	3.8%	4.2%	3.2%	1.4%
Twins (GGHC)	1:90	1:90	1:92	1:92	1:80	1:73	1:95	1:63	1:72
Twins (MM)	1:80								

Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912; Margaret F. Myles, *Textbook for Midwives* (Edinburgh: Churchill Livingstone (8th edn), 1975), pp. 317, 327; Matthew M. Garrey, A. D. T. Govan, C. Hodge and R. Callender, *Obstetrics Illustrated*, (Edinburgh: Churchill Livingstone, 1974), pp. 232, 260.

It can be seen that up to the 1912 Outdoor records, the percentage of breech deliveries was consistently higher than in the 1970s, although not excessively so. Presumably this was principally the result of a higher proportion of premature births. However, this analysis shows a considerably lower percentage of breech deliveries Outdoors in 1912. No immediate explanation presents itself, as no record suggests that any malpresentation other than transverse was grounds for admission, and there is no corresponding rise in the Indoor figures. Equally, in 1912 the proportion of twin deliveries Indoors and Outdoors is higher than in previous years, although the 1912 Outdoor figure is similar to that of Indoors in 1890. Here there is some explanation, as in 1912 six of the ten Indoor twin cases were admitted due to maternal ill-health. This brief examination suggests that the casebook figures are plausible.

Plausible or not, the casebooks are still not an easy source to use. The problems are varied. Legibility has already been mentioned, as has the disorder arising from multiple authorship. In the earlier years of the Outdoor books, medical students apparently entered each other's cases, or waited and entered their own in a block, covering a long period of time. In addition, the records are often incomplete, but

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[45] It should be noted that the two 1970s authorities cannot agree on the incidence of twins.

inconsistently so. For example, Table 1.2 shows the variation in recording maternal and infant outcomes in the four years studied in detail. This is most noticeable in the 1870 Outdoor cases when recorded by male or female pupils. In almost 10% of cases it is not recorded whether or not the child was born alive, and in 25% the boxes for the condition of mother and baby on discharge were not completed. However, it should be noted that the rarity of any maternal death in the dispensary almost invariably ensured a complete record in the casebook.

Table 1.2
Deficiencies in Recording Outcomes of Individual Cases at the ERMH in 1850, 1870, 1890, and 1912, as a Percentage of Deliveries

	1850 Indoor	1850 Outdoor	1870 Indoor	1870 Outdoor	1890 Indoor	1890 Outdoor	1912 Indoor	1912 Outdoor (main dispensary)	1912 Outdoor (Leith Branch)
Still-births Recorded	10.7	11.5	7.1	10.6	7.8	7.4	14.0	3.5	3.1
Data Not Recorded, or Unclear	0.0	1.6	6.5	9.9	0.3	0.3	1.4	2.0	0.0
Perinatal Deaths Recorded	13.0	14.7	13.6	12.1	11.6	9.3	18.7	5.3	5.3
Data Not Recorded, or Unclear	0.7	1.1	8.7	25.0	1.0	0.5	4.3	0.0	0.0
Maternal Deaths Recorded	1.5	0.5	0.5	0.5	1.4	0.6	4.1	0.2	0.0
Data Not Recorded, or Unclear	0.7	1.4	7.1	25.5	2.4	0.6	1.1	0.0	0.0

Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912; Students' External Casebook (Leith Branch), 1912.

Some of the incomplete records may be the result of the original function of the casebooks. The column headings in the Indoor and Outdoor Casebooks suggest that the books were not intended primarily to be records of treatment. Nor do they appear to have had any legal function. Instead they consist of regular, relevant observations on the nature of an individual's labour and its outcome. Janet McCalman suggests that Simpson hoped to create standards for improvement based upon scrupulous and detailed measurement and evaluation, for which such casebooks provided the raw

data.[46] Thus, the individual's record was part of a greater series of observations, and their treatment was not considered important. Simpson and Matthews Duncan used the data on duration of labour and outcome to support their arguments over intervention, but much of the ERMH data appears to have been unused. If it were being collected and analysed during much of Simpson's professorship, it is hard to imagine that any superior would tolerate the gaps in the casebooks that do occur. Examining deficiencies in current-day clinical records, H. Garfinkel has suggested that where 'uniform information is collected for future but unknown purposes', maintaining motivation among the recording personnel can be difficult, leading to poor reporting.[47] The history of the ERMH casebooks suggests this is one explanation for incomplete or non-existent records.

Other factors may also affect the collecting of information. For example, from January until August 1870 information on menstruation and quickening was rarely recorded, with the implication that it was equally rarely asked for, particularly once the previous page's columns were left unfilled. This reflects a combination of the effects of greater social delicacy and habit on some house surgeons, and illustrates the 'normal, natural troubles', the tendency to comply with established behaviour patterns, that Garfinkel also identifies as contributing to poor record-keeping.[48]

No space was provided for recording treatment or intervention, other than the 'Remarks' column, and this could cause confusion among the record-keepers, who felt such details should be added. Again, Garfinkel has written of the confusion that results from the reporter attempting to make his information fit the confines of the researcher's requirements, and therefore the use either of marginal notes, or of distortion of the facts to achieve conformity.[49] However, the great majority of ERMH casebook 'authors' appear to have taken the former step, and have not 'permitted the [book] to define the event'. Instead, whilst undoubtedly creating coding difficulties,

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[46] McCalman, *Sex and Suffering*, p. 11.
[47] H. Garfinkel, '"Good" Organizational Reasons for "Bad" Clinical Records', in H. Garfinkel, *Studies in Ethnomethodology* (New Jersey: Prentice-Hall, 1976), pp. 186-207.
[48] Ibid., p. 191.
[49] Ibid., pp. 195-7.

they have added greatly to the overall historical value of the casebooks by including a large number of case summaries and comments. Finally, the hospital offered no precise mechanism for recording cases who were admitted after delivery, or who died or were otherwise discharged before delivery. Again, the house surgeons appear to have solved this problem by recording such patients in the Indoor casebooks anyway, possibly on the basis of treatment received, but there is no way of knowing how consistent they were in this.

For 1912, the Students' External Casebooks constitute a further source of evidence of treatment. These have double-page entries, giving the patient's personal details, a record of the delivery similar to that in the Outdoor books, and an account of the daily visit made in the first ten days of the puerperium. The entries were made immediately after the visit, and in Leith, the nurse in charge, Sister C. Dewar, manifestly supervised the Branch book closely, commenting on cases and altering the numbering.[50] Cases in the Outdoor Book were copied from the main dispensary External Book, but did not include any from Leith, other than the occasional transfer. The Students' External Casebooks thus provide the only traced record of cases delivered in Leith. These books provide an extremely good source for details of the nursing management of the puerperium. In addition, whilst they undoubtedly illustrate the benefits of better supervision of record-keeping, their very existence and quality suggest that records of care given were more important to the hospital than formerly, implying that greater value was now attached to nursing.

The second category of casebooks were the Special and Ordinary Casebooks, also maintained by the house surgeons, but written in a narrative form. With the exception of the entries from August to October 1870, which comprise all the Indoor patients, these contain only cases deemed to be of greater than average interest, whose management was recorded for the benefit of future house surgeons. The idea of such

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[50] At case 141 in the original numbering, Sister Dewar wrote: 'See nos. 12, 51, 82, 89. Only labour & complete abortions to be counted as actual cases. C.D.,' and changed the case number to 136. (1912 Students' External Casebook (Leith Branch) [SECB(LB)], case 136a [141/136a/1912/Leith]). (Reference numbers in square brackets were assigned by the author).

records dates from the beginning of the ERMH,[51] but books survive only from mid-1870. These casebooks incorporate a wide range of literary styles, both in individual entries and in the way in which each quarter's entries were compiled. In part this reflects their multiple authorship. However, in 1912 and 1913 both Haultain's and Professor Halliday Croom's house surgeons employed a more formal style of presentation of cases than did Barbour and Ballantyne's housemen in the same years, suggesting that this stylistic approach was required of them. Different authors tackled the task of completing the book in different ways. In 1870 the cases appear to have been written up shortly after the events described: they follow the order of the main casebook closely, and were composed by the house surgeon most involved. In contrast, in 1890 each house surgeon in the quarter wrote up all his cases in turn, suggesting that completing this record was one of his last tasks in post, and he was able to reflect on the care given. By 1912 only Indoor cases were recorded, apparently at the time the events were occurring,[52] and one-sixth of all that year's Indoor cases (105) were reported in this casebook. As a source, these casebooks describe the medical treatment of cases in great detail, although the cases themselves are pre-selected and atypical.

However, these sources are not without problems. Again, they are completely handwritten throughout the period of this study, and, as with the annotations to the Indoor and Outdoor casebooks, some writers make considerable use of abbreviations and medical jargon. An additional danger in this is that whilst apparently modern medical language is often used in both sources, either its meaning may have subtly

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[51] In the 'Remarks' column of the entry recording Katerine Davidson's delivery on 25 April 1850, is the tantalising reference: 'Caesarian Section. ... Day Book 1216'. (1850 ICB, case 2037 [072/2037/50fi]).

[52] D. R. B. Sivwright, Haultain's senior house surgeon, allowed a double page for each entry, but repeated investigations of Mrs. I's pyrexia and slow recovery found him having to write in an ever-smaller hand to make it fit the paper available. (1912 Special & Ordinary Casebook [SOCB], pp.29-30; 1912 ICB, case 43 (Dr. Haultain's Quarter) [FWNH] [043/043/hault/1912i]). Later in the same year, Mrs M was admitted from Leith, 'sent in as an accidental haemorrhage ... pale & blanched ... restless ... well advanced in labour in fact the head was almost on the perineum'. Having described a delivery complicated by haemorrhage and a manual removal of placenta, A. G. Hunter's account ends, 'Previous History (got after patient somewhat recovered)...'. (1912 SOCB, p. 216; 1912 ICB, case 45 JHC [513/045/hc/1912i]).

changed, or, by looking familiar, it may give a false sense of security.[53] Further, with regard to narrative case histories, Harriet Nowell-Smith has suggested that they may be less ingenuous and objective than they first appear. She notes the origins of case-histories in the works of Hippocrates, and the way in which his evidence was built towards an inevitable and already-known outcome. She feels adopting this pattern gives published case-histories a strong moral sense, but that writing to a known conclusion may give a bias towards certain symptoms which at first seemed insignificant.[54] Indeed, some ERMH narrative case-histories do sound too 'text-book', Amelia Simes, for example, being described as of 'a decidedly anaemic appearance' in the ninth month of her twin pregnancy.[55] However, as has been shown, in 1912 the Special and Ordinary Book was used as an active record of treatment, preventing any bias in composition.

Nowell-Smith also suggests, from her study of published obstetric and gynaecological cases, that the exclusion of pronouns is a literary device to exclude the patient. She also feels that the social details given, which to her have no medical relevance, are a part of a formal scene setting, and are not intended to humanise the patient. Whilst these criticisms seem harsh when applied to in-house narratives, these accounts undoubtedly served an educational purpose for both the author and later readers, and it is possible to see them as part of a professionalisation process for young doctors. It is certainly true that, even when a detailed problem summary is given, the patient's voice is always mediated through the medical world. Nonetheless, despite their formality and their multiplicity of authors and styles, genuine medical emotion sometimes breaks through, and motivation can be seen. However, although the uncertain nature of their composition must be borne in mind, the Special and Ordinary casebooks provide an extremely rich and detailed source for the medical management of a selection of cases, often with some relevant social detail.

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[53] Noted by Ortrun Riha in his work on the extensive files of Göttingen University Hospital. Ortrun Riha, 'Surgical Case Records as a Historical Source: Limits and Perspectives', *Social History of Medicine*, 8 (1995), pp.271-83.
[54] Harriet Nowell-Smith, 'Nineteenth–Century Narrative Case Histories: An Inquiry into Stylistics and History', *Canadian Bulletin of Medical History*, 12, (1995), pp. 47-67.
[55] 1870 SOCB, p. 50.

Thus the clinical records of the ERMH have the potential to be a major historical source for the development of maternity care at the ERMH. By recording daily activity, they illustrate what doctors and the institution actually did, rather than what they wrote, or intended to do. For example, pain relief of any kind was apparently seldom used in the hospital practice where chloroform was first used on patients. Further, unlike doctors' own writings, clinical records provide evidence of the interaction between patients, their relations, and their doctors. In addition, the social detail provided by the Births Registers combines with the medical record and the intermittent social detail elsewhere, to locate the patients in the context of the city as a whole, and permits a picture of who used which department of the hospital. Further, the treatment recorded in the selected but more easily accessible individual cases of the Special and Ordinary casebook can be contrasted with the management of the normal majority, once extracted by data analysis. However, these clinical records are less effective, or perhaps less direct, at providing what Guenter Risse and John Harley Warner call 'the texture of hospital life'.[56] Nonetheless, considerable detail can be discovered, both from the registers and particularly from the narrative accounts. For example, in the absence of an ambulance, cabs were frequently used by hospital staff and relations to transport sick and labouring patients. When the clinical records are combined with Minutes and Annual Reports, much more detail of daily life can be seen or inferred. For example, the house surgeons' complaints to the Directors about poor ventilation and over-crowding can be seen to occur in a period with a higher than usual number of patients, infections and maternal deaths.

However, clinical records are a poor source of motivation towards particular medical plans of action except in individual cases, although the motivation can often be inferred. This also applies to the actions of patients in choosing whether or not to be admitted. Above all, the brief nature or formality of clinical and administrative records may have the effect of sanitising any description of the hospital based primarily on them. For example, Mrs Cornwell resigned as Matron after management

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[56] Guenter Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5, 1992, pp. 183-205.

complaints that she spent too much on good food for her patients, implying that food was normally poorer in quality and possibly quantity. On several occasions in the early 1870s Charles Bell criticised in dramatic terms the quality of care in the hospital, and its general squalor, but there is no hint of this in any account of inspection of the premises by the Directors.

Overall, the clinical and administrative records of the ERMH provide an extremely good source for the maternity care of a significant group of patients within Edinburgh. The principal problem is one of liberating the data from the disorder of a large number of hand-written casebooks and ledgers. How this has been tackled to show the development of maternity care through the hospital in the nineteenth and early-twentieth century is described in section 1.4.

1.3.3 Additional Source Material

In addition to the ERMH archive, a number of other sources have been used. These include the Edinburgh censuses, which provide both a snapshot of the staff and inmates at one time every ten years, and further social detail of some Outdoor patients, the matriculation and final examination records of the University of Edinburgh, and published medical registers and directories. These last four have yielded short biographical details for associated doctors and medical students. Medical journals have also been sampled for the writings of individual doctors, and the preserved lecture notes given to medical students in 1850 and 1905, and to a pupil midwife in 1910, have also been examined for evidence of contemporary approaches to labour and delivery.

1.4 Methodology

To examine the care given by the hospital it was decided to record all cases, both Indoor and Outdoor, in four discrete years, spread over the period of the study, 1844-1914. This gives a picture of the whole year, whilst reducing to manageable proportions the amount of data to be collected. In addition, it prevents the loss of occasional treatments or appearances that may occur through sampling. The number of cases actually recorded can be seen in Table 1.3.

Table 1.3
Number of Indoor and Outdoor Cases Recorded in each Year

	1850	1870	1890	1912
Indoor	291	188	294	634
Outdoor	564	404	666	1302

Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912; Students' External Casebook (Leith Branch), 1912.

Whilst the Births Register appears to contain all admissions, it was necessary both to negotiate the gaps in the Indoor casebook, and to select years in which the Outdoor book also appeared to be complete, in reasonable order, and with minimal exclusions. After 1870 it was also necessary to include the Special and Ordinary casebook in this. Thus the years 1850, 1870, 1890 and 1912 were selected for whole-year study, the last being chosen as the first full year available after a missing Special and Ordinary book. The first three years give a minimal gap before the census of the following years, which was also considered desirable. Linkage between the various records was made by patient name. However, there are discrepancies between the Indoor casebooks and the Births Register, and these can be seen in Table 1.4.

Table 1.4
Discrepancies in the Number of Indoor Cases Recorded at the ERMH, in the Years Studied

	1850	1870	1890	1912
Total Number of Patient Records Found	291	[α] 188	294	[β] 634
Number of Deliveries Recorded	270	184	294	630
Delivery Records as Percentage of Total	92.8%	97.9%	100.0%	99.4%

Source: ERMH Indoor Casebooks and Births Registers, 1850, 1870, 1890, 1912.

[α] This includes two women, who, after a week's stay in the ERMH, were found not to be pregnant.
[β] This includes three cases which are recorded in the Special and Ordinary Casebook, but not elsewhere. In one instance the mother died undelivered, and in the other two cases she was admitted after delivery at home.

Data were collected onto spreadsheets as shown in Appendix 1. This also shows the degree of calculation and manipulation used, although this has been kept to a minimum. Throughout the thesis, data are typically presented in number format, principally because those relating to treatment are extremely small. However, percentages are used when comparisons between years are made.

More interpretation of material is necessary in the area of persons carrying out and attending deliveries. The material used for this is taken from the entries made in the 'by whom delivered' and 'remarks' columns of the Indoor and Outdoor casebooks. In the first two years studied (1850 and 1870), it was the custom to record both the person who carried out the delivery, and the others present, usually distinguished by the hand-written addition of 'present'. On the few occasions where this is lacking, and two or more names appear, it has been assumed that the first name given is that of the person who carried out the delivery. In 1890 the 'by whom delivered' column in the Outdoor book was subdivided to give a separate entry for the nurses present, but the order of names has been followed as before. In 1912 information on those present at Outdoor deliveries comes both from the casebook itself, which was maintained as an internal ledger, and the Students' External Casebook. Outdoor deliveries in both 1890 and 1912 continued to list all those present in a plausible order, although when Sister Dewar attended a case in Leith, her name is often recorded first. However, Indoors in 1890 and 1912 the great majority of cases were ascribed to a single operator, usually the house surgeon. This implies that at this time only the person responsible for the case was recorded.[57]

The printed format of the books was never changed to formalise the recording of additional personnel present, although additions were apparently made consistently from 1849 to 1886. The purpose of recording the names of all those present was never formally stated, and the actual recording appears to have been at the whim of the house surgeon, but one can suggest that it was to provide evidence of attendance by students, and to convey shared responsibility.[58] Corroboration of these attendance figures is sometimes available in individual cases. These include the examination schedules completed by university medical students prior to their final examinations: the accuracy of these is discussed individually in the appropriate section. After 1872

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[57] The casebook entry for Mrs. H, who, according to the Special and Ordinary Casebook, was delivered by pubiotomy by Drs. Lackie and Sivright, ascribes the delivery to Lackie alone (1912 ICB, case 25 FWNH [025/hault/1912i], 1912 SOCB, pp.11-14). This can be compared with the forceps delivery of Jane Donald in 1850, at which six people are recorded as being present. (1850 ICB, case 2024 [059/2024/50fi]).

[58] In the later years of recording, Indoor midwife deliveries were initialled by the house surgeon. For example, when, on 30 September 1876, Nurse Macdonald delivered Susan Tuck, the then house surgeon, H. Stanley Nelson, added 'under the superintendence of H.S.N'. (1876 ICB, case 145).

the hospital issued itemised certificates to midwives: a similar medical student's certificate from 1887 also survives.[59] These suggest that pupils' experiences in the hospital were under-recorded in the casebooks. Although this material constitutes a weaker source than much of the ERMH clinical data, any opportunity to relate an individual's practical experience to their later career, and to examine in detail the staffing arrangements of, and the actual education given at a nineteenth-century maternity hospital and dispensary, is rare and should be taken.

[59] Certificate of Attendance at the ERMH of Robert Thin [LHB 3/38/23]. See also Illustration 5.2.

No.	NAME.	Age	Previous Labours.	Beginning of Last Catamenia.	End of Last Catamenia.	Quickening.	Date of Delivery. Month.	Day.	Hour.	Duration of Labour. First Stage.	Second Stage.	Third Stage.	Whole Labour.	Classification of Labours. Natural.	Laborious.	Preternatural.	Complicated.	Presentation and Position of Child.
2154	Catherine [illegible]	21	1	March		?	Sept.	17	11.55	7.0	1.45	1.15	9.55			1		Footling
2155	Annie [illegible]	26	3				Sept.	18	12.50					1				Head III
2156	Elizabeth Hay	30	1	?	?	?	"	18	1.40	5.0	2.30	0.10	7.40	1				Head I
2157	Eliza Cameron	24	1	December		April	"	20	10.15	10.0	3.10	0.5	13.15	1				Head I
2158	Elizabeth Redpath	26	4	December		"	"	19	2.50	5.0	1.31	0.49	6.50	1				Head I
2159	Jane Wyllie	20	1	January		?	"	19	9.0	8.0	1.40	0.20	10.0	1				Head I
2160	Elizabeth Walker	30	1	December		?	"	22	3.0	6.30	4.20	0.40	11.0	1				Head II
2161	Mary Brown	24	1	December		?	"	22	3.20	13.0	2.7	1.12	16.20	1				Head
2162	Isabella Stevenson	27	1	?	?	May	"	22	6.50	2.0	2.35	0.15	4.50	1				Head I
2163	Margt Temple	21	1	?	?	May	"	24	4.24	3.0	2.10	0.14	5.24	1				Head I
2164	Mrs Jamieson		2	Dec.	Dec.	April	"	24	8.5	6.30	0.20	0.10	7.5			1		Head I + Breech
2165	Janet Campbell	32	1	January	January	April	"	25	12.32	7.0	1.20	0.12	8.32	1				Head I
2166	Mary Wilson	26	1	Decemb	Dec.	April	"	27	1.0	4.0	2.42	0.18	7.0	1				Head I
2167	Catherine Leech	40	1	Dec.	Dec.	April	"	28	4.8	2.0	1.0	0.8	3.8	1				Head I
2168	Eliza Ferguson	23	1	~~Dec.~~	~~Dec.~~	?	"	28	5.30	4.0	1.6	0.22	5.30	1				Head I
2169	Mrs Carroll	25	3	Feb.	Feb.	?	"	28	11.10	Not known		1.10		1				Breech
2170	Jessie Elliot	18	1	Feb.	Feb.	June	Oct.	3	2.42	2.30	2.30	0.12	5.12	1				Head I
2171	Mary Griffith	20	1	Dec.	Dec.	June	"	4	6.17	4.31	12.35	0.13	15.17	1	1			Head I
2172	Emily Waters	25	1	"	"	April	"	4	2.35	6.30	0.55	0.10	9.35	1				Head I
2173	Mary Harding	36	5	Three years ago		May	"	5	5.25	10.1	6.15	0.10	16.25	1				Head I

Illustration 1.1 A Left-Hand Page from the ERMH Indoor Casebook for 1850

1850

Sex and State of Child.					Weight of Child.			Weight of Placenta.			Length of Child.	Length of Cord.	State of Leaving Hospital. Mother.	Child.	By whom Delivered.	References and Remarks.
Male.	Female.	Alive.	Dead.	Putrid.	Lbs.	Oz.	Drs.	Lbs.	Oz.	Drs.	Inches.	Inches.				
	1		1		6			1	6		15	18	Well	Dead	Dr. Hende H.S. Present Mr. Randell H.S. Mr. Kerr.	
	1	1			5	12		1	6		18	15	Well	Well	Dr. Hende H.S. Present Mr. Randell H.S. Mr. Kerr.	See case book Indoor Book 2 from page 1 to page 1866 of the book.
	1	1			7	12		1	2		18	21	Well	Well	J. Randell H.S.	
1		1			7	8		1	2		19	27	Well	Well	J. Randell H.S.	Cord once round the neck.
1		1			7	12		1	10		20	25	Well	Well	Dr. Hende H.S.	
1		1			7	8		1	6		21	25	Dead	Well	Dr. Hende H.S.	Dead of Puerperal fever.
	1	1			7	14		1	8		19	24	Well	Died	Dr. Hende H.S.	
	1	1			7	2		1	4		19	19	Well	Well	Mr. Johnstone.	
	1	1			5	14		0	14		18	24	Well	Well	J. Randell H.S.	
1		1			7	4		1	4		20	33	Well	Well	J. Randell H.S.	Present Dr. Hende, Mr. Richardson &
2		1	1		5	15		2	3		17	15	Well	Dead	J. Randell H.S.	This was a twin case book made, one
1		1			7	2		1	7		18	15	Well	Well	J. Randell H.S. Present Dr. Hende.	dead the other a living the head to right of Mother Convulsions, put Chloroform with hands.
	1	1			9	12		1	12		21	30	Well	Well	John Randell H.S.	
1		1			6	8		1	4		18	21	Well	Well	J. Randell H.S.	Thin membranous lining
1		1			7	12		1	6		20	18	Well	Well	J. Randell H.S.	
1			1		2	4		0	14		18	15	Well	Dead	J. Randell H.S.	The breech was down & the funis over the head Foot back Cord round body, funis & breech
	1		1		5	14		1	2		18	27	Well	Dead	Dr. Hende.	
1		1			8	12		1	8		20	21	Well	Well	J. Randell H.S. Present	Mr. Richardson, Clerk.
	1	1			9	8		1	12		20	27	Well	Well	J. Randell H.S. Dr. Hende &c.	
1		1			8	10		1	4		21	24	Well	Well	Dr. Hende H.S. Present Randell H.S.	

Illustration 1.2 The Right-Hand Page corresponding to Illustration 1.1 from the ERMH Indoor Casebook for 1850

No.	NAME.	Age.	PLACE OF RESIDENCE.	Date of Delivery. No. of Pregnancy	Month.	Day.	Classification of Labour. Natural.	Laborious.	Preternatural.	Complex.	Presentation and Position of Child.
17	Mary Jane Kirkpatrick	19	166 Pleasance	1st	July	23rd	"				Head & 1st
18	Bridget Mulhair	26	2 Blackfriars Street	3d	July	26th	"				Head 2nd
19	Mary Currie	34	114 St Leonard Street	5th	July	11th					Foot
1870 20	Mrs Urquhart	30	218 Canongate	5th	"	24th	"				Head & 2nd
1	Mrs Martin	29	126 Canongate	3rd	"	27th	"				Head & 1st
2	Mrs Owens	30	17 Gilmore St. Lauriston	6th	"		"				Head - 2nd
3	Mrs MacGlancy	40	295 Canongate	3rd	"	29th	"				Head 1st
4	Mrs Donally	26	295 Canongate	1st	"	30th	"				Head 1st
5	Mrs McMorran	26	56 Blackfriars Wynd	3rd	"	30th	"				Head & 1st
6	Mary Cockburn	37	9 Little Jacks Close Canongate	7th	"	27th	"				Head & 1st
7	Ellen Smith	24	112 Haddons Court, Infirmary St.	1st	"	29th	"				Head & 1st
8	Mrs Duncan	21	3 Cannon Place	1st	Aug	1st	"				Head & 1st
9	Jemima Pickren	25	6 Blackfriars Wynd	3d	Aug	9	—				Head & 1st
1870 10	Mrs Fairbairn	40	24 New Street	8th	"	8th	"		Yes		Breech Head 1st
1	Mrs Quarley	31	8 St. Johns Hill	5th	"	8th			Yes		Breech
2	Mrs Bradley	32	Allisons Close	7th	"	9th	"				Head
3	Mrs Dailey	30	116 Canongate 4th Flat	3rd	"	13th	"				Head 1st
4	Ann Reilly	24	295 Canongate	3rd	"	10	"				Head 1st
5	Mrs Nisbet		47 Lady Lawsons Wynd	6th	"	15	"				Head 1st
6	Mrs Burke	20	84 Abbey Hill	1st	"	14	"				Head 1st

Illustration 1.3 A Left-Hand Page from the ERMH Outdoor Casebook for 1870

Sex and State of Child.				Event to		By whom delivered.	Remarks.
Male.	Female.	Alive.	Dead.	Putrid.	Mother.	Child.		
/		/			Well	Well	S P W Rouse	
"		"			Well	Well	S P W Rouse	Cord once round the neck
"		"			Well	Well	Mrs Handley	
/		/			Well	Well	K. McChristchon	Cord twice round neck
/					Well	Well	K. McChristchon	Retained Placenta
/		"			Well	Well	W. John Turner by H.S.	Mrs Sutherland present
/		"			Well	Well	K. McChristchon	
/					Well	Well	K. McChristchon	
/					Well	Well	Mrs Campbell	Very large child - 10 lbs -
/		/			Well	Well	S P W Rouse	Cord once round the neck
"		"			Well	Well	S P W Rouse	
"		"			Well	Well	S P W Rouse	
"		"			Well	Well	S S Donald	Cord twice round neck.
"		"	—		Well	Well	Midwife - [illegible]	Retained Placenta - Removed by Dr Kennedy -
—		"	—		Well	dead	Mrs Sutherland	Child still-born
		"			Well	Well	Mrs Sutherland	Child born with a caul.
/		/	—		Well	Well	W. Wood H.S.	Perineum slightly ruptured
		-			Well	Well	S. S. Donald	~~Retained Placenta~~ -
—		/	—				Mrs Mitchell (nurse).	W. Wood H.S. present.
/		/			Well	Died	Edward Moon Wilson	Child only lived 17 hrs.

Illustration 1.4 The Right-Hand Page corresponding to Illustration 1.3

from the ERMH Outdoor Casebook for 1870

Chapter 2

The Edinburgh Royal Maternity Hospital in Context

2.1 Introduction

This chapter places the Edinburgh Royal Maternity Hospital [ERMH] in various contexts. Official attitudes in Edinburgh to maternal and infant mortality in the period 1843-1914 are discussed, and the hospital located within these. The maternity care options available to pregnant women in nineteenth and early twentieth century Edinburgh are described, as is the history of the hospital, and its links with charitable and educational interests. The roles of the hospital staff, and the changes in these over time, are analysed, as are the male and female pupils associated with the ERMH and its place in their midwifery education. Finally, using original sources and with particular emphasis on Edinburgh births during the nineteenth and early twentieth century, the management of non-institutional deliveries is described to create a context for the treatment provided by the ERMH, both Indoor and Outdoor.

2.2 Maternal and Infant Mortality in Edinburgh

Reports of maternal and infant deaths were published annually by the Registrar-General for Scotland from 1855. In 1866 it was noted that whilst in the country as a whole there were '39 deaths in every ten thousand mothers',[1] '59 mothers died for every ten thousand children born alive in the Eight [principal] Towns'. In Edinburgh the equivalent figure was 64 maternal deaths per 10,000, in Glasgow 57, and in Aberdeen, 38.[2] During the 1860s and 1870s, approximately one in 200 mothers died, recorded outbreaks of 'metria' (puerperal infection) apparently having only a small effect on the national figure, although the recording registrars were aware that their information was not always sound. In the 1869 Annual Report, James Stark noted 'that the mortality of women in childbed is lower in Scotland than in any other

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[1] Registrar-General for Scotland [RGS] *Twelfth Detailed Annual Report of the Registrar-General of Births, Marriages and Deaths in Scotland* (Edinburgh: Murray and Gibb, 1869), p. xxxviii.
[2] RGS, *Twelfth Annual Report of the Registrar-General on the Births, Marriages and Deaths Registered in Scotland During the Year 1866* (Edinburgh: Murray and Gibb, 1867), p. 24.

country',[3] and despite an increase in recorded maternal mortality to 1:156 live births (64 per 10,000) by 1883, the Registrar-General for Scotland remained complacent.

Maternal mortality was not a major issue in Edinburgh. In 1862, following a tenement collapse, Henry Littlejohn was appointed Medical Officer of Health for Edinburgh.[4] His principal targets for many years were the poor quality of Edinburgh's housing, and the control of infectious disease in the city. He did refer to the need for 'an enlarged Maternity Hospital', in his *Report on the Sanitary Condition of the City of Edinburgh*, but because the 'miserable houses of the poorer description of the labouring population render [it] an urgent necessity for the preservation of maternal and infantile life, not to speak of the common decencies of life',[5] not because it would directly improve mortality statistics. From 1899 he published an annual report on the health of the city. In that year he noted that there were only five deaths from puerperal fever (in 8097 live births), but felt that 'this represents a too favourable mortality from this disease, and that some deaths, ... which ought to be counted under this heading, are ascribed to subsidiary conditions which do not indicate the true nature of the disease'.[6] In 1902 puerperal fever became a notifiable disease in Edinburgh. The number of reported cases steadily declined, and in 1912 only three deaths from this cause were recorded in the city by Littlejohn's successor, A. Maxwell Williamson. There were a further 23 childbirth deaths in the city, giving a maternal mortality of '3.6 per 1000 births'.[7] Thus maternal mortality was not seen as an urgent issue in Edinburgh.

However, all three sources noted the steady loss of infant life in Scotland, the high infant death rate becoming more obvious as the number of childhood deaths from

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[3] RGS, *15th Detailed Annual Report of the Registrar-General of Births, Marriages and Deaths in Scotland, 1869* (Edinburgh: Murray and Gibb, 1873), p. xxxvii.
[4] E. F. Catford *Edinburgh: the Story of a City* (London: Hutchison & Co. Ltd., 1975), p. 193.
[5] Henry D. Littlejohn *Report on the Sanitary Condition of the City of Edinburgh* (Edinburgh: Colston & Son, 1865), p. 75.
[6] Henry D. Littlejohn *Annual Report of the Medical Officer of Health of the City of Edinburgh for the Year 1899* (Edinburgh: H. & J. Pillans & Wilson, 1900), p. 16. There were 27 other deaths in childbirth.
[7] A. Maxwell Williamson (Medical Officer of Health) *Annual Report of the Public Health Department of the City of Edinburgh for the Year 1912* (Edinburgh: H. & J. Pillans & Wilson, 1913), p. 12. There were 6700 births in total.

infectious disease declined.[8] Within the city, infant deaths due to prematurity, the largest single cause, remained intractably at about 2% of recorded births from 1899 on, eventually providing the main stimulus to the introduction of the Edinburgh Maternity Scheme. In this the Corporation provided additional funding for ante-natal supervision of patients attending the ERMH and its associate dispensaries, thereby removing the maternity care of the extreme poor of Edinburgh from charitable to local government care.[9] Thus, although by then Edinburgh had a large maternity hospital and dispensaries, as will be shown, and medicalisation of childbirth was far advanced, as in other British cities and towns it was concern about infant survival and a falling birth-rate, not maternal health, that urged the Council into action.[10]

2.3 Maternity Care Options Available in Nineteenth and Early Twentieth-Century Edinburgh

On finding herself pregnant, a woman in nineteenth-century Edinburgh had a number of options available, depending upon the depth of her pocket and her personal inclination, but all attendants not associated with charities were privately engaged. Probably the most expensive were medical 'specialists' of good reputation, who combined practice with an academic role. As an example from the mid-nineteenth century, James Young Simpson was in established practice both in Edinburgh, and much further afield, from approximately 1840 until his death in 1870.[11] Early twentieth century evidence comes from the autobiography of Eleanor Sillar. She describes herself as the daughter of 'the Sheriff', and the wife of 'William, doctor and university lecturer'. She was also a member of the Ladies' Committee of the

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[8] Michael Flinn *Scottish Population History from the Seventeenth Century to the 1930s* (Cambridge: Cambridge University Press, 1977), p. 386. However, infant mortality in nineteenth-century Scotland was not as high as in England, possibly due to lower urbanisation, a point also made in Rosalind Mitchison *British Population Change since 1860* (London: Macmillan Press Ltd., 1977), pp. 49-52.
[9] H. P. Tait *A Doctor and two Policemen* (Edinburgh: Mackenzie and Storrie Ltd., 1974), p. 150.
[10] See, for example, Maxine Rhodes, 'Municipal Maternity Services: Policy and Provision 1900-1939 with Particular Reference to Kingston-upon-Hull and its Municipal Maternity Home' (Hull University Ph.D. Thesis, 1996); Lara Marks, *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939* (Oxford: Clarendon Press, 1994); Hilary Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme 1903-1920', *Social History of Medicine*, 6 (1993), pp. 25-50.
[11] Myrtle Simpson *Simpson the Obstetrician* (London: Victor Gollancz Ltd., 1972). He also had a non-midwifery practice, mainly among children.

ERMH. During the period 1895-1905 she was delivered once by Professor Halliday Croom, and twice by Dr Milne Murray, then assistant physician at the ERMH.[12]

The family's own general practitioner could be retained, with a range of female assistants. At Eleanor Sillar's own birth in 1870 (she was the eighth of nine children), the doctor was assisted by the already-employed family nurse, who stayed with the family until Eleanor's adulthood.[13] Alternatively, a specially-employed monthly nurse, again engaged by the family, could assist. For example, at the birth of John Inglis' son in 1879, both a doctor and a nurse (described by Inglis as a 'howdie') attended. It is not clear whether the doctor would have been called had labour been less protracted, but almost certainly he would, as he also visited in very early labour, before the arrival of the nurse, Mrs Lawson. Inglis paid Dr Moir £1 10s, which he considered 'very moderate', and Mrs Lawson 15/- and her keep for approximately three weeks.[14] A similar nurse was employed for the birth of Elaine Wilson (daughter of an Edinburgh merchant) in 1911, and for those of her younger brother and sister in 1913 and 1915.[15] The GP could also be actively assisted by a close female relation, as distinct from the supportive role of the patient's mother or friends described, for example, in Edinburgh Medical Missionary Society doctors' accounts.[16] A fictional account of the active role is described by Conan Doyle in 'The Curse of Eve', although this story might have resulted from his Southampton rather than his Edinburgh experiences, and has a Camberwell setting.[17]

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[12] Eleanor Sillar *Edinburgh's Child - Some Memories of Ninety Years* (Edinburgh: The Mercat Press, 1979), pp. 144-8.

[13] The long service might be unusual, resulting from the death of the mother 16 months later, 'a few days' after the birth of her ninth child. However, this does not detract from the nurse's role at delivery. (Sillar, *Edinburgh's Child,* pp. 158-62).

[14] John Inglis (ed. Ena Vaughan) *A Victorian Edinburgh Diary* (Edinburgh: The Ramsay Head Press, 1984), p. 35. Inglis was chief clerk and cashier in a legal firm; his wife was a teacher and the daughter of a missionary. They lived in Rintoul Place, and appear to have kept no domestic help. Mrs Lawson advertised herself as a ladies' nurse in the Post Office Directory; Inglis personally recommended her to a colleague.

[15] Elaine Mary Wilson *Tak' Tent o' Time: Memories of a Post-Edwardian Childhood* (Edinburgh: Plenderleath Publishing, 1992), pp. 7-8, 13-4, 47.

[16] H. F. L. Taylor *A Century of Service 1841-1941* (Edinburgh: Edinburgh Medical Missionary Society, n. d.), p. 202.

[17] Arthur Conan Doyle, 'The Curse of Eve', in *Tales of Adventure and Medical Life* (London: John Murray, 1963 paperback edition), pp. 146-57.

The doctor might not necessarily attend himself, as some employed an unqualified assistant. These posts, for medical students who had done midwifery, were advertised; Dr C. B. Gunn had such a job when a medical student in Edinburgh in about 1880.[18] Dr R. R. Rentoul believed such posts gave vital experience to students, and that the development of a body of registered midwives would, by ending assistantships, deprive them of this.[19] Meg Henderson's account of her aunt's death gives an example of such an assistant being employed (illegally) as late as 1959.[20]

Alternatively, a private midwife could be employed. It is difficult to estimate the number of births attended by such midwives in Edinburgh. In 1892 Dr W. Graily Hewitt reported to the Select Committee on Midwives' Registration that in 1869 the London Obstetrical Society had attempted to collect information from its members about the attendants at deliveries in their area. Their findings were that there were virtually no midwife deliveries in Edinburgh, although they delivered 75% of Glasgow births.[21] Quantitative data on attendants became available only after the introduction of birth notification in the early twentieth century, when midwives were described as taking 2% of cases in Edinburgh in 1911,[22] rising to 9% in 1922.[23] However, midwives, including some qualified at the ERMH, continued to advertise in the Post Office Directories, although their numbers did fluctuate.[24] Throughout the period of this study, failure to attempt to provide professional attendance at birth was not an offence, and there is a smattering of evidence, both in the casebooks and

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[18] Clement Bryce Gunn *Leaves from the Life of a Country Doctor* (Edinburgh: The Moray Press, 1935), pp. 24-5. Dr Gunn, an exact contemporary of Conan Doyle, qualified in 1882.
[19] Parliamentary Papers [P.P.], *Report of the Select Committee on Midwives' Registration* 1892 (289) XIV, pp. 1-173, Evidence of Dr R. R. Rentoul qq:370-433.
[20] Meg Henderson *Finding Peggy: A Glasgow Childhood* (London: Corgi Books, 1995), pp. 154-62, 272-99.
[21] P.P., *Report of the Select Committee on Midwives' Registration* 1892 (289) XIV, pp. 1-173, Evidence of Dr W. Graily Hewitt q:1148.
[22] A. Maxwell Williamson, *Annual Report of the Medical Officer of Health of the City of Edinburgh, 1911*, p. 24.
[23] Tait, *A Doctor and Two Policeman*, p. 152.
[24] Barbara Mortimer has charted the decline in self-advertisements by Edinburgh midwives, arguing that the traditional neighbourhood midwife was in terminal decline in the city by the mid-nineteenth century. Such women now preferred to present themselves as ladies' nurses. (Barbara E. Mortimer, 'The Nurse in Edinburgh c.1760-1860: The Impact of Commerce and Professionalisation' (Ph.D. Thesis, University of Edinburgh, 2002)). However, the numbers of midwives had recovered slightly by 1900.

elsewhere, of births being attended by a non-professional, often the patient's mother. However, the Notification of Births Act revealed this to be a very small number.[25]

Not all women were able to afford private care at delivery. The birth notification data revealed that free or subsidised care from Edinburgh charities was received by 26% of women in labour in 1909, increasing to 30% in 1910 and 35% in 1911.[26] Attendance in the patient's home was provided by a great number of dispensaries, of which the ERMH Outdoor provision was by 1910 the largest. Other charities are described below.

2.3.1 The Royal Public Dispensary and Vaccination Institution

This was established in 1776 to provide practical experience for medical students and free treatment for the poor. In 1899 the Burdett report claimed it had 5,906 patients, including 146 midwifery cases.[27] It was staffed by medical students with a supervising doctor, and was almost certainly the 'Royal Dispensary' represented by Dr Andrew at the meeting of 'maternity' charities held in 1889, at which the fees to be charged by all dispensaries for medical students' practical midwifery experience were settled.[28]

2.3.2 The New Town Dispensary

When this was established in 1816, it had two physician-accoucheurs on its staff, and emphasised its charitable role, in contrast to the perceived educational function of the Edinburgh General Lying-In Hospital and the Royal Public Dispensary.[29] However, it also used medical students. Between 1836 and 1842 it delivered 1,132 maternity

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[25] A. Maxwell Williamson, *Annual Report of the Medical Officer of Health of the City of Edinburgh, 1911*, p. 24.
[26] A. Maxwell Williamson, *Annual Report of the Medical Officer of Health of the City of Edinburgh , 1909*, p. 5; *Annual Report of the Medical Officer of Health of the City of Edinburgh, 1910*, p. 18; *Annual Report of the Medical Officer of Health of the City of Edinburgh, 1912*, p. 17.
[27] H. C. Burdett, *Hospitals and Charities*, published in 1899, and quoted in Olive Checkland *Philanthropy in Victorian Scotland: Social Welfare and the Voluntary Principle* (Edinburgh: John Donald, 1980), p. 201.
[28] Medical Board Minutes [MBMERMH], 5 June 1889.
[29] *Observations by the Managers of the New Town Dispensary on the Report to the Quarterly Meeting of Managers of the Public Dispensary, 7th August 1817* (Edinburgh: Caledonian Mercury Press, 1817).

patients, whilst Burdett says it treated 9,170 patients (undefined) in 1879.[30] At the 1889 meeting it was represented by Dr Cadell, who also acted as principal spokesman for all the dispensaries.

2.3.3 The Edinburgh Lying-in Institution

This was also established in 1816, and was specifically a maternity charity. Patients were to be attended in 'their own houses' by midwives and 'medical gentlemen' with a doctor in support, although its casebook suggests that, even before entries stop in the 1840s, patients were mainly attended by medical students. It was claimed (in the Report for 1824-5) that the Edinburgh Lying-in Institution [ELII] had delivered 446 patients, and 308 in 1831-2.[31] Qualified medical support was given, if needed, by one of the Drs Thatcher (father, son or grandson), who also lectured in midwifery from their base in Picardy Place. However, ELII failed to send a representative to the 1889 meeting. This, combined with the failure to record cases for approximately half a century, suggests that it was at that time a very small enterprise. However, the Burdett report of 1899 says that it had 114 cases that year,[32] and casebook entries restart in 1903, when the names of pupil midwives are recorded.[33] In the 1820s it claimed to have a bed in its base in Niddry Street, and in the early twentieth century it operated a maternity home and antenatal clinic at 13, Chalmers Street. This achieved Central Midwives Board (Scotland) recognition as a midwifery-training centre in about 1919, but was closed following Charles Thatcher's death in 1933.

2.3.4 The Edinburgh Medical Missionary Society

Founded in 1841, this housed and sponsored previously-selected students through medical school, who then received midwifery and other practical experience through the Cowgate Dispensary. In 1870s the Edinburgh Medical Missionary Society [EMMS] had an establishment of ten students, three doctors, five Biblewomen-

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[30] Burdett, *Hospitals and Charities*, quoted in Checkland, *Philanthropy in Victorian Scotland*, p. 203.
[31] *First Annual Report of the Edinburgh Lying-in Institution for Delivering Poor Married Women at Their own Houses* (Edinburgh: Murray and Mitchell, 1825) p. 9; *Eighth Annual Report of the Edinburgh Lying-in Institution for Delivering Poor Married Women at Their own Houses* (Edinburgh: Andrew Jack & Co., 1832).
[32] Burdett, *Hospitals and Charities*, quoted in Checkland, *Philanthropy in Victorian Scotland*, p. 201.
[33] The midwifery memorabilia of Jessie Cuthbert, trained by ELII in 1910, is in the Lothian Health Services Archive [LHSA].

nurses, and two servants, headed by the Superintendent, Dr William Burns Thomson.[34] It also had close connections with both Professors Simpson and the ERMH. Mrs Stevenson, ERMH Matron 1873-5, had previously been one of its nurses.[35] The then Superintendent, Rev. John Lowe F.R.C.S., was invited to attend the 1889 meeting. In 1894-5 the EMMS treated 352 midwifery cases.[36]

2.3.5 The Fountainbridge Dispensary

Founded in 1871, this was represented at the 1889 meeting by its physician-accoucheur, Dr Barbour (also an assistant physician at the ERMH). It was later known as the Western Dispensary.

2.3.6 The Edinburgh Provident Dispensary, Marshall Street

This was established in 1878, and represented by Dr Mathison at the 1889 meeting.[37] It was again staffed by students, but by 1912 it also employed its own midwife, J. L. Green, as well as a female medical officer.[38]

2.3.7 The Hospice, 219 High Street

This was established with an all-female staff in 1903. Its casebooks contain regular references to nurses after 1906, and to Jubilee nurses after 1910, although the majority of patients were attended by qualified doctors. The nurses appear to have conducted the delivery whilst the doctor gave chloroform, apparently routinely. If the nurses acted independently of the doctor, they had to justify their actions. Between 1905 and 1908 the Hospice had 60-100 external cases annually, with an apparently increasing number of admissions after 1908.[39] Tait describes the dispensaries in

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[34] Checkland, *Philanthropy in Victorian Scotland,* pp. 81-2.
[35] ERMH Directors Minutes [DMERMH], 31 July 1873.
[36] John Wilkinson *The Coogate Doctors: the History of the Edinburgh Medical Missionary Society, 1841-1991* (Edinburgh: Edinburgh Medical Missionary Society, 1991), p. 35.
[37] Checkland, *Philanthropy in Victorian Scotland,* pp. 206-7. Some medical students recorded their attendance there on their examination schedules.
[38] *The London and Provincial Medical Directory, inclusive of the Medical Directory for Scotland, and the Medical Directory for Ireland, and the General Medical Register* (London: J. and A. Churchill, 1912), p. 1468.
[39] LHSA, The Hospice, Record of confinements, Volume I, October 1903-23 June 1908; Volume II, 24 June 1908- 30 October 1909; Volume III, 30 October 1909-19 August 1912.

Grove Street (established in 1878 by Sophia Jex-Blake) and Gorgie as its subsidiaries by 1917.[40]

2.3.8 *Richmond Street Dispensary*

This dispensary is listed separately by Checkland as being in operation by 1875.[41] However, among the medical students' statements of midwifery experience in about 1870, are references to 'Dr M. Duncan, [presumably James Matthews Duncan] Royal Dispensary, Richmond Street'.[42] From contemporary Medical Directories the only charities with which he was involved were the ERMH and the Royal Public Dispensary. A separate Richmond Street Dispensary did not send a representative to the 1889 meeting, and one is forced to conclude that it was synonymous with the Royal Public Dispensary.

Checkland also lists the Port Hopetoun Public Dispensary and Humane Society (38 Fountainbridge Street, established 1830), and a further dispensary in Rose Street. There is no suggestion whether they offered midwifery or not.[43]

In-patient maternity care was much rarer. The small provision at ELII and the Hospice has already been noted. In addition, after its opening in 1870, some births occurred in Craiglockhart Poorhouse, although, as will be shown, some deliveries seem to have been conducted at the ERMH and then the patients sent or returned to Craiglockhart. Otherwise the ERMH was the sole provider of in-patient maternity care in Edinburgh during the period studied.

2.4 The Edinburgh Royal Maternity Hospital

Thus, when it opened in 1844, the ERMH was one of a group of lying-in charities in Edinburgh, whose number increased during the latter half of the nineteenth century, and whose senior staff were often interconnected. However, the origins of the ERMH were different. When Professor Alexander Hamilton opened the Edinburgh General

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[40] Tait, *A Doctor and Two Policeman*, p. 151.
[41] Checkland, *Philanthropy in Victorian Scotland*, p. 204.
[42] See, for example, the examination schedule of William Wylie (University of Edinburgh Special Collections, Medical Examinations for 1870: Wylie).
[43] Checkland, *Philanthropy in Victorian Scotland*, p. 204.

Lying-in Hospital [EGLIH] in 1793, he did so principally to continue to provide concentrated hospital and community midwifery experience for his pupils. In recognition of the demands this made of patients, these were initially rewarded with gifts of money, tea and sugar, as well as free attendance at their confinement.[44] Thus, although the clientele was poor, the emphasis was less on the relief of their poverty, than on accessing teaching material. This difference of emphasis was recognised by contemporaries.[45] Further, the EGLIH provided in-patient treatment, unlike the charitable dispensaries. On Hamilton's death, the EGLIH was sold in settlement of his estate, the Edinburgh Maternity Hospital being opened as a replacement ('Royal' was used in its title from 1846).[46] This hospital described itself as a charity and gave precedence to its ordinary directors over the Medical Board, but it was very much the heir of its predecessor. The current Professor of Midwifery was still associated with it as one of the ordinary medical officers, and it was the beneficiary of financial gifts and loans from him.[47] Like the EGLIH, it was committed to providing practical midwifery experience to male and female pupils, and it was partly dependent on the income they yielded. Its Rules[48] emphasised the importance to it of its pupils, summarised the hospital's expectations of them, and the training it intended to provide. Other dispensaries, whilst also providing cases for male and female pupils, chose to emphasise their charitable role.

In the early years the ERMH provided in-patient care for no more than 24 patients at a time, described hereafter as Indoor cases, and domiciliary care for a far greater number, described hereafter as Outdoor cases. In addition, at some periods it operated a Dispensary for women and children. One casebook from this, covering the period 1844-8, survives, and, being complete, suggests the Dispensary survived

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[44] *Statement Regarding the New Town Dispensary, by the Medical Gentlemen Conducting that Institution* (Edinburgh: William Blackwood, 1816), p. 37.
[45] *Statement Regarding the New Town Dispensary*, p. 37.
[46] Ziegler's evidence to the Poor Law Inquiry (see below, note 54) implies a continuous sequence from EGLIH to ERMH via a shadowy lying-in hospital housed in the ex-fever hospital in Surgeon-Square.
[47] In 1856 Simpson lent money to the directors to enable them to purchase Chapel House. (DMERMH, 2 May 1856).
[48] *Rules and Bye-Laws of the Edinburgh Maternity Hospital* (Edinburgh: Andrew Murray, Printer, Milne Square, n.d.).

beyond this date.[49] In 1860, 'Drs Simpson, Zeigler and Keiller' appealed to the directors to re-establish the 'Dispensary for Infants and Children', which had evidently been closed due to lack of funds. This was agreed on harsh terms by the directors: the doctors were to provide all medicines, meet all gate-keeping expenses, give all associated student fees to the hospital, treat only non-infectious infants under two years, and then only as out-patients. Drs Ziegler and Sidey, who worked in the Dispensary, were to have no other connection with the hospital.[50] Mention is made of the medical staffing of the Dispensary in the undated Rules, the ordinary medical officers apparently being expected to attend both the Dispensary and the hospital.[51] However, after this, no reference to this Dispensary has been found. The Dispensary evidently provided medical students with experience of infants' medicine, but it also appears to have made demands of time and money on its associated doctors for no immediate return. However, it would have had an educational effect on the mothers attending, which might have encouraged them to turn to the ERMH for maternity care.

The ERMH occupied a number of sites in its early years. In its first 12 years it moved four times, from St. John Street, to Milton House, Minto House, and thence to Chapel House, which it occupied for 20 years. Building and industrial work close to Chapel House rendered it less suitable as a hospital, and in 1872 the ERMH was allowed to move into Watson's Hospital, 'the best accommodation it had yet enjoyed', prior to its conversion to the Royal Infirmary. However, in 1874 the ERMH was moved on again, back to St. John's Street. Its final move for 60 years was in 1879, to the custom-built maternity hospital at 79 Lauriston Place, funded by the national fund 'collected to perpetuate the memory of Sir James Simpson'.[52]

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[49] LHSA, Maternity Hospital Dispensary Book, 1844-8.
[50] DMERMH, 13 March 1860.
[51] *Rules and Bye-Laws*, 'Ordinary Medical Officers', Rule 5; 'Ordinary Surgeon', Rule 2; 'Assistant Medical Officers', Rule 3.
[52] A. R. Simpson, 'Sketch of the History of the Royal Maternity and Simpson Memorial Hospital', in G. A. Gibson, C. W. Cathcart, D. Berry Hart (eds.), *Edinburgh Hospital Reports*, Vol.1 (Edinburgh and Leeds: Young J. Pentland, 1893), pp. 46-7.

The frequency of the hospital's moves in its early years suggests that its survival was marginal. This is further supported by its funding difficulties. It received money from a number of sources. In 1843 Alexander Ziegler described the lying-in hospital as 'supported only by voluntary contributions ... [which] may average 100*l*. a year ... [and] by the fees of the pupils who attend it', and the voluntary attendance of its medical officers. He also stressed that it had no legacies, and that 'unless some means for its support can be devised, more liberal, and less precarious ... it must ... be broken up'. Whilst the ERMH did survive, receiving, in addition to sources given by Ziegler, subscriptions from local parishes on behalf of potential patients, and some payments for their board from ante-natal patients,[53] its finances continued to be precarious throughout the period studied.

However, Ziegler also pointed out the lack of public support for the hospital as a concept. It 'has never received from the public that countenance to which it is entitled, both as a most useful charity, and as a school of instruction for practical midwifery'.[54] This prejudice prevailed until the end of the nineteenth century: even in 1895 Dr John Moir could speak about 'a good deal of feeling against supporting the Maternity Hospital',[55] although this does not seem to have extended to its Outdoor provision. It seems to have had its roots partly in public attitudes to its originally largely single inmates, and partly in a fear that supporting the hospital was in some way sponsoring immorality. Evidence of this can be found in the swift internal criticism of Mrs Johnston's management in 1861, when alcohol was consumed by a male visitor in the hospital, rendering it 'like a brothel',[56] and in the Ladies' Committee's suggestion that 'girls from houses of a disreputable character' should not be admitted.[57] The implications of many of Mrs Milne Murray's criticisms of the hospital, made in about 1907, are that treatment was given

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[53] The earliest Rules imply antenatal shelter was paid for (*Rules and Bye-Laws*, 'Patients', Rule 5), and this is supported by references in the summarised accounts to 'from patients and midwives for Board and lodging ...' (DMERMH, 11 December 1856). However, the incomplete notebook LHB 3/12/A, kept from 1871-3, records some payments, but also that other patients would pay when able.
[54] P.P., *Report from Her Majesty's Commissioners for Enquiring into the Administration and Practical Operation of the Poor Laws of Scotland*, 1844 (563) XX, evidence of Mr. Alexander Ziegler, q: 2613.
[55] DMERMH, 26 September 1895.
[56] DMERMH, 27 July 1861.

grudgingly: for example, there was little privacy and the food was poorly presented.[58] Further, it was commonly believed that married and single patients were nursed together despite the opening of a Married Women's Pavilion in 1894, and therefore patients were not willing to use the hospital.[59] Thus it could be suggested that the hospital itself delayed, rather than encouraged, medicalisation of childbirth in Edinburgh. Its approach in the early twentieth century seems divided. In the report of the sub-committee appointed to reply to Mrs Milne Murray's comments, the directors apparently wished to expand the medical aspects of the hospital. However, six years before, they had regretted the rising mortality rate that accompanied an increasing number of cases admitted 'after outside endeavour has failed',[60] seeming uncertain about the purpose of the hospital, whether it was to provide expert care in obstetric emergencies, or shelter to the destitute pregnant. Anxieties about patients' attitude towards the ERMH were still evident in 1913, when it was feared by both directors and doctors that the introduction of National Insurance benefits would allow patients to afford other trained medical help, leaving the hospital doubly disadvantaged. It would both lose training cases and be unable to compete as it was staffed by pupils who were, by definition, unqualified.[61] Indeed, whilst from 1875 the overall number of in-and out-patients rose slowly but steadily, as shown in Appendix 2, patient numbers in all departments dropped in or around 1913.

2.5 Hospital Staff

2.5.1 Senior Doctors 1850-1912

The undated *Rules and Bye-laws of the Edinburgh Maternity Hospital* describe a hierarchy of doctors, with, as the most senior, consulting medical officers and a consulting surgeon. Their involvement was to be limited to giving 'their attendance

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[57] DMERMH, 8 December 1876. The suggestion was rejected.
[58] Margaret Milne Murray, *The Practical Training in Midwifery of the Edinburgh Medical Student: An Appeal to the Senatus of the Edinburgh University, the Directors of the Royal Maternity Hospital, and to the Physicians of that Institution* (printed privately, 1908).
[59] J. R. Middleton and R. Robertson, ERMH Report by the Sub-Committee for the Board of Directors, 13 July 1908, pp. 6-7.
[60] ERMH Annual Report [ARERMH] for 1901.
[61] ARERMH for 1912, 1913; DMERMH, Memorandum for the National Insurance Commissioners, 29 November 1912. Ballantyne reported a 'falling off in the Indoor cases ... specially evident in the married women'. (MBMERMH, 24 September 1913).

in all cases of difficulty, when requested to do so'.[62] Sir James Simpson and Dr John Moir were described as consulting physicians in 1870, whilst Alexander Ziegler was consulting surgeon from at least 1853 until his death in 1863.[63]

Next were the Ordinary Medical Officers (also called ordinary physicians), of whom there were to be two, each having 'the entire control and responsibility' for half the Indoor patients, unless these required the services of either the consulting physicians, or the ordinary surgeon.[64] They were to attend the hospital daily, arranging approved cover if this was not possible, and were also to give advice to 'Out-patients' attending the Dispensary.[65] They did not have complete freedom of treatment, however, being required '[i]n cases of danger or peculiar interest ... [to], when practicable, request the attendance of all the other members of the Medical Board'.[66] The ordinary surgeon was similarly competent to attend the Dispensary, but was otherwise limited to taking 'charge of any surgical diseases .... [H]e shall not interfere with the obstetric practice, or with obstetric operations, unless specifically requested to do so ....'[67] These posts, whilst honorary, were very desirable, representing a degree of acceptance and establishment in the Edinburgh obstetric scene. James Matthews Duncan unsuccessfully applied for posts in 1856, 1860, and 1863, but was rejected. He was appointed Ordinary Physician in 1870.[68]

The lack of clarity about the date of composition of the Rules means it is impossible to know whether the level of commitment described above was expected from the opening of the ERMH, or whether it represents Simpson and Moir's demands of their colleagues in 1863-4. Although the caseload was not great (typically there were five

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[62] *Rules and Bye-Laws*, 'Consulting Medical Officers, and Consulting Surgeon', Rule 1. It has been suggested that this, the earliest surviving list of ERMH rules, dates from 1864, when they were revised, and their revision is recorded in detail in the Directors' Minutes. However, 'Royal' had been consistently used in the hospital title since 1846, and its absence from the title page of these Rules suggests that they predate this.

[63] Lists of ERMH staff in the Medical Directories for 1853 and 1870: Ziegler had previously been surgeon to the EGLIH.

[64] *Rules and Bye-Laws*, 'Ordinary Medical Officers', Rule 1.

[65] *Rules and Bye-Laws*, 'Ordinary Medical Officers', Rules 2, 3, 5.

[66] *Rules and Bye-Laws*, 'Ordinary Medical Officers', Rule 4.

[67] *Rules and Bye-Laws*, 'Ordinary Surgeon', Rules 2, 1.

[68] DMERMH, 17 March 1856, 13 March 1860, 13 July 1863, 25 July 1870.

to 24 in-patients),[69] the requirement of daily attendance was burdensome. Actual attendance may have been somewhat different. In 1861 the Directors wrote of securing 'the attendance of a visiting physician ... each month of the year',[70] implying this had not previously been available, whilst in 1872 the Matron complained that 'no Medical Officer had visited the hospital for a fortnight at a time'.[71]

The doctors' commitment to the ERMH in the period before 1871 has been assessed using their attendance at administrative meetings. Prior to March 1860, they do not appear to have attended directors' meetings.[72] Between then and December 1862, a group representing the Medical Board attended on three occasions and in March 1860 this group was specifically described as the medical officers, Simpson, Keiller and Ziegler. On the other occasions the group also included Moir, Weir and Thomson. After this date, when there was increasing evidence of degeneration in the hospital, doctors attended more frequently, both to complain and to take part in plans for reform. Between 1863 and the temporary closure of 1869, there were 27 meetings, although these were not evenly distributed. Moir appears to have been most involved in the ERMH, attending 24 of these meetings. Simpson attended 14, Keiller 13, and Bell 11. However, the ERMH was not the only charity with which the senior doctors were associated on a professional level. Simpson was also Physician Accoucheur at the New Town Dispensary, Superintendent at the Carrubber's Close Dispensary, and, in 1870, Vice-President of the Edinburgh Medical Missionary Society [EMMS]. Moir was a founder-member of the same Society. Alexander Keiller was Physician Accoucheur at the Royal Provident Dispensary, and also held another honorary physicianship at the Royal Hospital for Sick Children.

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[69] In 1862 Matron complained of recent over-crowding to the Directors, as there had been 30 patients in the hospital, and was told to restrict numbers to 24 'except in cases of great emergency, such as being in labour' (DMERMH, 22 February 1862). On census night in 1851, there were 11 adult patients, and in 1871, five. (N. R. and S. Carstairs (compilers), *Edinburgh 1851 Census*, Volume I, *The Canongate*, (Scottish Genealogy Society, 1993), p. 279); RGS, *1871 Census of the City of Edinburgh*, Registration District 685[4], Enumeration Book 70).

[70] DMERMH, 27 July 1861. This may, of course, precede the Rules.

[71] DMERMH, 7 March 1872.

Prior to 1870, two senior doctors only had teaching commitments. During the university winter session, Simpson, as Professor of Medicine, Midwifery and the Diseases of Women and Children, lectured daily. He also offered weekly clinical lectures and 'Examinations and Demonstrations in Obstetric Operations'.[73] Both Keiller and Matthews Duncan lectured regularly at the Extra-mural Medical School, hence the latter's desire to be appointed to a hospital post. Keiller presented unusual cases he had attended with his students to the Edinburgh Obstetrical Society (later published in the *Edinburgh Medical Journal*),[74] suggesting that he was an active practical teacher. His testimonial from the hospital speaks of 'the ability which has characterised Dr Keiller's lectures and instructions in midwifery'.[75] However, Moir, Weir and Bell never held teaching posts. Moir enjoyed a reputation as a skilled family doctor, popular as an accoucheur among his medical colleagues' families.[76] Thus, in the early years of the ERMH, although honorary hospital posts were desirable as a form of publicity, in the small world of midwifery in Edinburgh any senior doctor involved was likely to see the ERMH as one of a number of charities with which he was associated, each of which conferred equal status. His reward for his involvement was a mixture of self-advertisement and recognition of his philanthropy. His involvement represented one of a series of discrete activities associated with his knowledge of midwifery. Sharing his knowledge through teaching was not necessarily a part of this.

Following Simpson's death in 1870, and the appointment of Alexander Simpson to the Professorship, the hospital went through a period of constitutional reform, emphasising thereby the continuing dominance of the lay directors. The Professor was *ex officio* a member of the Board of Directors, but no other ordinary physician was to belong to that Board, or to the House Committee. The physicians were to express their opinions through the Medical Board, to which the directors made the

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[72] This is based on the first surviving volume of Directors' Minutes (the second), which begins with the move from Minto House to Chapel House in 1856.
[73] *Edinburgh University Calendar*, 1858 (Edinburgh: Thos. Constable, 1858), p. 28.
[74] Edinburgh Obstetrical Society, session XIII, *Edinburgh Medical Journal* [*EMJ*], V (1855), pp. 476-80.
[75] The testimonial accompanied his application for the professorial chair left vacant by Simpson's death (DMERMH, 14 July 1870).
[76] See his obituary in the *British Medical Journal*, 27 May 1899, pp. 1311-2.

appointments. The introduction of minuted meetings gave this a more formal appearance. An early reform was the division of the hospital year into quarters, for which each ordinary physician was responsible in turn. Moir's suggested division in November 1871 incidentally provides confirmation of increasing teaching activity. He recommended that the Professor should have November to January, Matthews Duncan February to April, and Keiller May to July: '[t]hese three gentlemen are the only Lecturers on Midwifery and they for the sake of their pupils should have a preference.'[77] In 1877 it was decided that these posts should be held for ten years. When James Dunsmure was appointed consultant surgeon in 1878, no new ordinary surgeon was appointed, and it will be seen that later operations were carried out by the ordinary physician for the quarter. After Dunsmure's retirement, the post of consultant surgeon was held by the Professor of Surgery.

In 1884 'the Directors ... resolved to appoint two Assistant Physicians', apparently based on a report from the medical faculty.[78] Debate about their function followed: whether they 'should have entire charge of the Outdoor Cases', (presumably to increase the quality of the supervision of medical students attending Outdoor cases), and how responsibility for cases should be transferred to them.[79] Initially each assistant physician served two ordinary physicians for six months, but in 1900 the number of posts was doubled, so that each became more closely linked to an ordinary physician.[80] Appointment to these posts guaranteed an ordinary physician's post in due course: both Underhill and Berry Hart, who were the first appointees, were ordinary physicians within six years. Barbour, who replaced Underhill, served less than twelve years before promotion. However, progress towards an assistant physicianship could be slow: Francis W. N. Haultain was house surgeon at the ERMH in 1883, assistant physician in 1900, and ordinary physician by 1904. Similarly James Lamond Lackie, house surgeon in 1890, took 15 years to become assistant physician. With the possible exception of H. O. Nicholson in 1912, all

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[77] MBMERMH, 1 November 1871. The fourth (summer) quarter fell to William Ziegler.
[78] MBMERMH, 4 April 1884.
[79] MBMERMH, 16 April 1884.
[80] MBMERMH, 10 January 1900.

assistant physicians were already experienced lecturers in midwifery: Haultain had been a regular lecturer at the Edinburgh School of Medicine since 1895.[81]

The introduction of the post of Assistant Physician is significant. Firstly, the directors were governed by the wishes of the Medical School, and both recognised their role as providers of practical medical education, and showed that they understood their responsibilities to their public, in particular the growing number of women who used the Outdoor services. It can be said that by increasing the available medical cover, they reduced the burden on the ordinary physicians, but they also showed they understood that the management of childbirth was becoming perceived as complex and in need of medical supervision. Finally, such a post gave professional recognition, and linked rising young obstetricians to the hospital.

In other areas the balance between the charitable interests of the directors and the educational and medical roles of the doctors became harder to maintain. In 1871 disagreement arose when Alexander Simpson's plans to have 'a ward ... set apart as a clinical university-ward to be attended by the Professor ... [and also a] small [room] ... for occasional cases' were rejected by the directors, 'owing to the ... want of accommodation ...'.[82] At various times the directors recorded the conflict between the Ladies' Committee and the doctors, usually triggered by their teaching practices and requirements. In 1871 the Ladies were prepared to resign over the introduction of vaginal examinations 'before students, ... which they considered demoralizing'. Unfortunately, the directors' decision was not recorded.[83] However, the directors did attempt to restrict the increasing role of the house surgeon. In 1898, they drafted new rules which expressly forbade him 'under any circumstances, [to] apply instruments, or perform any important obstetric operation, except under the immediate direction of the Medical Officer', although, as will be shown in Chapter 4, this had been common practice by the doctors for at least the previous eight years, and would

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[81] The careers of senior doctors associated with the ERMH have been drawn principally from their entries in contemporary Medical Directories, augmented by references in hospital administration papers, and, in the case of Lackie, a summary of his life in D. H. A. Boyd *Leith Hospital 1848-1988*, (Edinburgh: Scottish Academic Press, 1990), p. 66.
[82] MBMERMH, 1 November 1871.
[83] DMERMH, 19 March 1871.

continue to be so.[84] Equally, they did not intend the appointment of assistant physicians to reduce the responsibility of the ordinary medical officers. '[O]n every occasion in which the Medical Officer delegates duty to an Assistant Physician he shall record the fact in a book left for the purpose assigning reasons for having done so.'[85] Nonetheless, when fundraising, the directors chose increasingly to emphasise the educational aspect of the hospital's work.[86]

Senior doctors continued their professional association with other dispensaries after 1870. As before 1871, the majority had long-term connections with one or two: for example, Alexander Simpson was associated only with the EMMS, whilst John Halliday Croom was Medical Officer and Consulting Physician in the Diseases of Women to the Fountainbridge/Western Dispensary, and one of 46 directors of the EMMS. Exceptions were Barbour, who was associated with four other charities, including the Women's Dispensary he founded, and Berry Hart and Ziegler, who were only associated with the ERMH.

Medical education provided the major growth area for senior doctors. In 1870 the Medical Directory noted three lecturing posts in Edinburgh in the area of midwifery and the diseases of women, whilst four of the nine doctors associated with the ERMH in that year apparently never taught. In 1889 Alexander Simpson declared a policy of trying to get lecturers appointed to staff posts at the ERMH, these to be 'equally divided between the University and the Extra Mural School',[87] and by 1890, six of the ten lecturers in what had become 18 posts, were associated with the ERMH. By 1895 there were 32 such teaching posts, held by 13 lecturers, eight of whom were linked with the ERMH. By 1900, when there were 27 such lecturing posts, all the hospital medical staff lectured, and only one lecturer in an appropriate subject (Brewis, in gynaecology), was unconnected to the ERMH. In 1912, again

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[84] MBMERMH, 6 July 1898.
[85] MBMERMH, 16 April 1884.
[86] The Annual Report for 1870 stated that: '[t]hey desire to combine a proper school for the instruction in Midwifery ... with a charity to the poor and needy....'; likewise the 1893 report declared, when fundraising for the Married Women's Pavilion, that '[a]s an educational establishment the Hospital is of the greatest importance ...'. (ARERMH for 1870, 1893).
[87] DMERMH, 7 February 1889.

excepting Brewis, 12 of the 13 lecturers had posts with the ERMH and the associated dispensaries.[88] Of the active hospital staff, only H. O. Nicholson, assistant physician to Ballantyne, appears not to have taught in this period.

In the last quarter of the nineteenth century, in contrast to earlier years, an active role in education was necessary for the senior doctors to progress in their careers. It was no longer possible for an ordinary physician at the ERMH to combine this only with general practice, or with medical support for another charity, although this continued. In addition, the number of active senior doctors associated with the hospital increased. In 1870 there were four, plus an ordinary surgeon; by 1890 there were six, increasing to eight by 1906. These changes appear to have been driven largely by the increasing demands for medical midwifery education arising from the expansion of the medical schools. Educational demands also drove a further change to the number of senior doctors, which occurred in 1908. In connection with changes in the practical experience of medical students, it was decided to incorporate the six obstetric physicians of the associated dispensaries into the hospital staff as 'extern physicians'.[89] Although they maintained professional independence, some later progressed to assistant physicianships at the ERMH. In the careers of the senior doctors can be seen an expansion in their numbers rather than their activities, but also an increase in their status arising from their more public role as teachers, a wider range of hospital posts, and an increased use of the hospital as performance space, through cliniques and operations. Their careers show the increasing professionalisation of obstetrics.

2.5.2 House Surgeons 1850-1912

House surgeons were the most senior grade of trainee at the hospital. In the early years, whilst they were officially appointed by the Directors, their professional competence was to be verified by the Medical Board, for which they had to show '... evidence that they have attended one course of Lectures on Midwifery and the Diseases of Women and Children, and understand the management of natural

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[88] There were 31 posts.
[89] ARERMH for 1908.

labour'.[90] Posts were advertised, and candidates apparently selected by prior knowledge or study of testimonials.[91] During the period studied, the relationship between the house surgeon and his ordinary physician became one of more direct patronage, until by 1909 the physician made the selection.[92] Most house surgeons were newly qualified doctors, or senior students.[93] Throughout the period examined, two were in post at any one time. In 1850, 1870, and 1890 they were in post for three months at a time, for which they paid 4 guineas, and also, separately, for their board and lodging.[94] By 1912 a house surgeon stayed six months, spending three months on the district, followed by three months in the hospital. After 1909 he was paid one guinea a week for his second (senior) three months.

House surgeons' duties included charge of the In- and Out-patients, and the maintenance of accurate registers. The Indoor house surgeon was to examine each patient on admission, and if she were in labour, to summon a small class, and explain 'the nature of the case'. He was responsible for summoning help from the Ordinary Medical Officer 'on the occurrence of difficulty or danger', and also for the medication and general care of the patients.[95] Thus he had both a duty to his pupils and to his patients. However, he was also forbidden to 'perform any important obstetric operation except under the direction of one or more of the Medical Officers', a rule which was reiterated, but was apparently frequently broken in the

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[90] *Rules and Bye-Laws*, 'House Surgeons', Rule 6.
[91] See DMERMH, 24 October 1870, 17 April 1871.
[92] See MBMERMH, 15 January 1909.
[93] In 1850, George Harley took his final examinations when in post. In 1871 John Thomson included in his pre-qualification practical midwifery experience '7 months 1868-9 House surgeon R.M.H.' (1871 Medical Examinations: Thomson). In 1871, Joseph Vicente Forfar, who had been the keenest of the students the year before, was described in the census as 'house surgeon, medical student' (RGS, *Census of the City of Edinburgh*, 1871, Registration District 685[4], Enumeration Book 70). After the 1870s, from the records of their names and qualifications on the flyleaves of the casebooks, house surgeons appear to have been qualified. Final-year students were again employed during World War I but the practice was criticised by the Corporation when setting up the Maternity Scheme in 1917. (Ronald H. Girdwood, 'Association with the Edinburgh Medical School', in *The Royal Infirmary of Edinburgh 1729-1979; The Simpson Memorial Maternity Pavilion 1879-1979* (anniversary pamphlet), p.18; Edinburgh City Archives, 'Report by Councillor John A. Young on the Evolution and Development of Public Health Administration in the City of Edinburgh 1865-1919' (includes details of Edinburgh Maternity Scheme) [SL26/5/1], p. 38).
[94] In September 1872, G. H. Mackenzie told the Medical Board that he could not afford both fees and board, and declined the offer of a House Surgeonship. (MBMERMH, 3 September 1872).

years 1890 and 1912.[96] The Outdoor house surgeon was responsible for an equitable distribution of cases amongst the pupils, and for ensuring that 'a fully competent Pupil is sent as early as possible to each case'. He was to attend any case when requested by the pupil, and to send for help if necessary. Both house surgeons were responsible for the behaviour of the pupils towards their patients.[97]

The Rules imply that there was a daily ward round with the Ordinary Medical Officer,[98] but beyond this, in the early period there was apparently very little supervision of the house surgeons, who interpreted their instructions in their own way. By 1912 the job requirements were largely defined in the Regulations. The junior house surgeon was responsible for 'the outdoor cases and ... the Leith Branch', the appropriate casebooks, and the Birth Notifications.[99] He also assisted Indoors as necessary, including urine testing, 'the sideroom work', and dispensing.[100] The Senior admitted patients and maintained all Indoor records as before, but was also responsible for preparing patients for cliniques and accompanying them, teaching, and distributing Indoor cases to pupils. In addition he composed a Monthly Report on the hospital for the various Boards, and spent one day a week in charge of all Outdoor cases, whilst the Junior managed those Indoors.[101] On completion, if the house surgeons produced 'satisfactory evidence that [they had] regularly discharged their duties and complied with the Rules of the Institution', they received a certificate from the Medical Board.[102]

As the immediate medical representative of the hospital, the house surgeon's role can be seen as remaining stable. However, the changing requirements of the post-holder indicate both increasing medicalisation of childbirth, and the growing complexity of

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[95] *Rules and Bye-Laws*, 'House Surgeons', Rule 3; *Constitution and Laws of the Edinburgh Royal Maternity Hospital and Simpson Memorial Hospital*, (Edinburgh: Oliver and Boyd, 1905), 'House Surgeons', para. 3.
[96] *Rules and Bye-Laws*, 'House Surgeons', Rule 5; *Constitution and Laws*, 'House Surgeons', para. 3.
[97] *Rules and Bye-Laws*, 'House Surgeons', Rule 4; *Constitution and Laws*, 'House Surgeons', para. 9.
[98] *Rules and Bye-Laws*, 'House Surgeons', Rule 3; *Constitution and Laws*, 'House Surgeons', para. 6.
[99] Edinburgh Royal Maternity and Simpson Memorial Hospital, 'Regulations for House Surgeons, sanctioned by the Directors on 22nd March, 1911', Rule 7.
[100] MBERMH, 18 June 1909.
[101] 'Regulations for House Surgeons, ... 1911', Rule 5.
[102] *Rules and Bye-Laws*, 'Medical Board', Rule 2. See, for example, DMERMH, 31 May 1871.

the hospital organisation. The changing relationship between the house surgeon and his ordinary physician, taken with the changes in service of the assistant physicians, suggest the development of 'firms' similar to those in the Infirmary.

2.5.3 Medical Students 1850-1912

During the eighteenth century, midwifery became an increasingly popular subject for medical students at Edinburgh, and the commercial motivation for this has been examined in detail by Lisa Rosner and Irvine Loudon.[103] Christopher Hoolihan has asserted that the midwifery education available in eighteenth-century Edinburgh eclipsed that of London or Paris. His examination of Thomas Young's surviving lectures indicates that they improved annually, and were supplemented by anatomical models, plates, and demonstrations of instruments. Practical experience was provided in the lying-in ward, established by Young in the Royal Infirmary.[104] In 1793 Alexander Hamilton, Young's successor, having quarrelled with the managers of the Infirmary over the numbers of his students, established the Edinburgh General Lying-in Hospital. By 1815 James Hamilton, Alexander's son and fifth professor, had over 400 students, and in 1826 he conducted a successful campaign for midwifery to become a compulsory course for degree students in Edinburgh. This was in contrast to England, where, for much of the nineteenth century, it was possible for a student at an English medical school to graduate without any midwifery experience. Only in 1886 did it become necessary for medical students at English medical schools also to attend a course of lectures on midwifery and the diseases of women and children, with three months' practical experience, before qualification. Prior to this the Scottish medical schools were exceptional in demanding such midwifery experience before graduation or membership.

Despite the greater recognition of midwifery as a medical topic in nineteenth-century Scotland, the basic method of teaching it actually changed very little in Edinburgh, being structured around the lecture course. Throughout the period of this study, in the

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[103] Lisa Rosner, Students and Apprentices: Medical Students at Edinburgh University 1760-1810 (Johns Hopkins University Ph.D. Thesis, 1985), pp. 120-44, 330; Irvine Loudon *Medical Care and the General Practitioner 1750-1850* (Oxford: Clarendon Press, 1986), pp. 87-8.

university winter session the Professor gave daily lectures, as did the midwifery lecturers of the extra-mural school. In addition, in 1858 James Young Simpson offered '[w]eekly Examinations and Demonstrations in Obstetric Operations.[105] However, by 1885 Alexander Simpson also offered his students the opportunity to study midwifery clinically

> in the Royal Maternity, of which the professor is ... one of the medical officers ... [He] makes a special Clinical visit with [students] who have taken the maternity ticket .... [T]utorial classes are formed for Practical Instruction in the use of Obstetric and Gynaecological Instruments and appliances.[106]

In 1890 additional clinical instruction was introduced, by 'one of the Assistant Physicians'.[107] Individuals could also take assistantships or become house surgeons or dressers whilst still students. Following the introduction in 1858 of medical registration, with its necessary requirements for qualification, medical courses in Britain became increasingly standardised, and gradually the course content became more academic.[108] Instead of learning through work and repetition, students were increasingly instructed formally in the practical aspects of medicine, possibly as a result of increasing numbers of students, or as a result of increasing supervision.

After Hamilton's intervention in 1826, Edinburgh medical students wishing to graduate had to have attended 100 lectures in midwifery and the diseases of women and children, and either spent three months at a maternity hospital, or have a certificate of attendance on six cases from a recognised medical practitioner.[109] In 1888 this requirement changed to 12 cases under the superintendence of a registered medical man, or hospital experience, including six cases.[110] In 1910 the General Medical Council [GMC] changed this to 25 cases of labour under supervision as

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[104] Christopher Hoolihan, 'Thomas Young M.D. (1726?-1783) and Obstetrical Education at Edinburgh', *Journal of the History of Medicine*, 40 (1985), pp. 327-45.
[105] *Edinburgh University Calendar*, 1858, p. 28.
[106] *Edinburgh University Calendar*, 1885-6, pp. 90-2.
[107] *Edinburgh University Calendar*, 1890-1, pp. 341-2.
[108] Charles Newman, *The Evolution of Medical Education in the Nineteenth Century*, (London: Oxford University Press, 1957), pp. 100-11.
[109] The first recordings of this requirement found are in the *Edinburgh University Calendar*, 1861, p. 90, and, for the Royal Colleges, in the Medical Directory for 1861, p. 804 (*The London and Provincial Medical Directory, inclusive of the Medical Directory for Scotland, and the Medical Directory for Ireland, and the General Medical Register* (London: John Churchill, 1861).
[110] *Edinburgh University Calendar*, 1890-1, pp. 354-6.

above, or to 'have attended for three months the practice of a Lying-in Hospital, or of the maternity department of a general hospital or other Public Charitable Institution, and have conducted personally *twelve* ... cases'.[111]

Those who attended the ERMH were typically in their final year of study, when midwifery was recommended in study programmes, although not all were matriculated students. Some, as will be shown, were from the Extra-Mural Medical School, or were studying away from their 'home' university. The Rules required them to have attended, or be attending, a recognised lecture course in midwifery and the diseases of women, and most combined their theoretical and practical learning. By 1910 the GMC required that before students took their practical midwifery they should 'have held the offices of Clinical Medical Clerk and Surgical Dresser, and have attended a Course of Lectures on Surgery and Midwifery', so that they were not completely without practical experience.[112]

Despite the emphasis on the importance of pupils to the ERMH, their entry to the hospital, and thus to practical experience, was restricted. Pupils could only enter at 'the hour of visit', or when allowed by a house surgeon or one of the Medical Officers.[113] After 1881 those who were attending infectious cases or the post-mortem or dissecting rooms were summarily excluded.[114] Pupils were expected to deliver primarily Outdoor cases, once 'the House-Surgeon, in charge of the Out-cases, is fully satisfied that [the pupil] is capable'.[115] Pupils were to go to their patient as soon as they were called, to stay until an hour after delivery, and visit regularly until the woman was convalescent, and especially in the first 24 hours. In difficult cases, they were to call the house surgeon. Failure to attend after accepting a case, or poor treatment of patients, was subject to reprimand by the Medical Board; repetition of such offences led to dismissal by the directors.[116] At the time the oldest Rules were

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[111] *Edinburgh University Calendar*, 1911-2, pp. 525-6.
[112] *Edinburgh University Calendar*, 1911-2, pp. 525-6.
[113] *Rules and Bye-Laws*, 'Pupils', Rule 1 (lectures), Rule 2 (admission).
[114] J. Halliday Croom, 'The Systematic Use of Antiseptics in Midwifery Practice', *EMJ*, XXVI, No.VIII, p.718.
[115] *Rules and Bye-Laws*, 'Pupils', Rule 3.
[116] *Rules and Bye-Laws*, 'Pupils', Rule 8.

composed, pupils paid £1 3s. for their practical midwifery experience at the hospital; after 1889 they paid the standard charge made by all charitable dispensaries in Edinburgh: 1gn. for six cases, and 2gns for 12, plus 1gn. for three months internal clinical instruction.[117] In 1912 they paid 3gns for 3months 'Internal Clinical Instruction and 12 practical cases'.[118]

In 1878 Halliday Croom introduced a clinical midwifery scheme, whereby students were formally taught in cliniques, around the patient's bedside, or by demonstration. This reduced the emphasis on 'hands-on' practical experience, and, due in large part to the increase in the number of students, there was a decrease in the number of cases offered to individuals by the hospital. This decline in practical experience was criticised by Dr Robert Milne Murray during an address to the Edinburgh Obstetrical Society in 1901. He proposed a new scheme with pupils living in the hospital, and having a concentrated introduction to midwifery by attending all cases occurring in a month.[119] By 1904 the scheme was in operation, with four students in rotation in residence, taking alternate Indoor and Outdoor cases. Completion certificates were only granted if the student had attended half of the Indoor cases, two-thirds of the Medical Officer's rounds, and taken 'a due proportion' of Outdoor cases.[120] It proved extremely unpopular with the student body, and by 1907 the Faculty of Medicine was pressing for its withdrawal, and the introduction of a different arrangement. Under this, students registered with the hospital would attend the Indoor practice daily for a month, and then, when considered competent for Outdoor practice, would attend an associated dispensary, supervised by the 'External Obstetric Physicians of the Maternity Hospital'.[121]

The nature of the medical students' practical experience at the ERMH, and the manner in which they were taught, changed considerably over the period of this study. The records suggest that demonstrations to cliniques increased in importance

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[117] *Rules and Bye-Laws*, 'Pupils', Rule 10; MBMERMH, 5 June 1889, DMERMH, 13 April 1891.
[118] *Edinburgh University Calendar*, 1911-2, p. 488.
[119] This is quoted in full in Margaret Milne Murray, *The Practical Training in Midwifery of the Edinburgh Medical Student*, pp. 4-5.
[120] *Constitution and Laws*, 'Pupils', para. 9.
[121] *Edinburgh University Calendar*, 1911-2, pp. 525-6.

in preference to practical experience towards the end of the century. National and local anxiety about the quality of obstetric care led to a renewed emphasis on practical experience, but the scheme adopted at the ERMH ensured the absence of individual medical students from the casebooks by 1912.

2.5.4 Nursing Staff

The hospital had a Matron from its inception, and, although her role was still described largely in administrative terms in 1909,[122] with the exception of Mrs Hay (appointed in 1869), she was a midwife. On Mrs Hay's appointment, the additional but temporary post of Head or Superintendent Nurse was created.[123] Throughout the period of this study, the great majority of the nurses were trainees, and 'each acting physician ha[d] to begin and conduct his quarter with a new and often most incompetent set of women, who, without any previous instruction, come to be trained as nurses'.[124] Anxieties about the high infection rate in the new hospital building led in 1881 to the introduction of the additional post of Staff Nurse, a 'permanent trained nurse', to supervise the introduction of a more rigorous antiseptic regime, and 'to see that the inexperienced new nurses carry out all the precautions necessary for the patients' safety'.[125] By the time of the 1899 puerperal fever outbreak it was evidently felt that that the system worked, as all staff 'discharged their duties efficiently and conscientiously'.[126] In 1909 a permanent Indoor Sister was appointed to support the Matron. When the Leith Branch opened in 1907, the post of Sister there was also permanent.

2.5.5 Female Pupils 1850-1912

The background to midwifery training for women in Edinburgh in the nineteenth century is considerably more complex than that for men. In general, evidence for the training of midwives in early-modern Britain is limited, and confused by the midwife's dual role on the one hand as safe deliverer of the mother in a physical

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[122] 'Edinburgh Royal Maternity Hospital and Simpson Memorial Hospital Regulations for Matron As Handed to Miss Barclay, Approved 17th March 1909' (LHSA, LHB 3/22/5).
[123] DMERMH, 6 October 1869.
[124] Halliday Croom, 'The Systematic Use of Antiseptics in Midwifery Practice', p. 721.
[125] Ibid., p. 721.
[126] Part of Berry Hart's report to the Board on the closure. (MBMERMH, 23 March 1899).

sense, and on the other as guardian of the rite of birth in a cultural sense. In some communities she had an additional role as moral guardian, extracting evidence of paternity, or swearing to the maturity of the child.[127] Further, prior to the Midwives Acts, (1902 in England and Wales, 1915 in Scotland), vocational training was not compulsory, nor even considered necessary before starting work.[128] Different types of training were popular at different times and in different areas.[129]

During the eighteenth century more formal education for midwives was developed, consisting of a series of lectures plus practical instruction from a medical man, possibly associated with a lying-in hospital. There is some debate about the motivation for improving midwifery standards. The desire to upgrade such standards appears to have been an international phenomenon, occasioned by the fear in many countries of depopulation through declining live birth rates, and conversely, their increasing need for manpower. This argument was prevalent in Scotland, as well as France and Denmark, but less used in England.[130] Edinburgh in particular feared a decline in the population after the Act of Union. In 1726, Joseph Gibson, a surgeon from Leith, was appointed City Professor of Midwifery by the Town Council, ostensibly to improve the quality of midwifery in the city, and to administer a new licensing scheme for midwives.[131] The control of midwifery in the capital was, at least in theory, transferred to medical men, both at the level of applying for a licence

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[127] Jean Towler and Joan Bramall *Midwives in History and Society* (London: Croom Helm, 1986), p. 57.
[128] See Mrs. Layton, 'Memories of Seventy Years', in Margaret Llewelyn Davies (ed.) *Life as We Have Known It* (London: Hogarth Press Ltd., 1931, and Virago Publishing, 1977), p. 43.
[129] See, for example, Doreen Evenden, 'Mothers and their Midwives in Seventeenth Century London', in Hilary Marland (ed.) *The Art of Midwifery: Early Modern Midwives in Europe* (London and New York: Routledge, 1993), pp. 9-26, which examines apprenticeship, and Jean Donnison *Midwives and Medical Men: a History of the Struggle for the Control of Childbirth* (London: Historical Publications (2nd Edn.), 1988), pp. 21-2, which suggests that formal apprenticeship was likely to be financially worthwhile only in a large town. In rural districts there would have been too few births to recoup the outlay. See also, Anna Giardina Hess, 'Midwifery Practice among the Quakers in Southern Rural England in the Late Seventeenth Century', in Marland (ed.) *The Art of Midwifery*, pp. 49-76; Irene Jones, 'Elizabeth Davies, Midwife. 1853-1927', *The London Hospital Gazette*, 73 (1970), pp. 9-12; Nicky Leap and Billie Hunter *The Midwife's Tale* (London: Scarlet Press, 1993), pp. 25-6.
[130] William Baird *George Drummond: an Edinburgh Lord Provost of the Eighteenth Century* (Edinburgh: T. & A. Constable, 1912), pp. 7, 15, 26; Anne Løkke, 'The "Antiseptic" Transformation of Danish Midwives, 1860-1920', in Hilary Marland and Anne Marie Rafferty (eds), *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period* (London: Routledge, 1997), pp. 102-33; Donnison, *Midwives and Medical Men*, pp. 51-2.
[131] Hoolihan, 'Thomas Young M.D.', pp. 327-45.

to practise midwifery, and in controlling the education necessary for that licence. Similarly structured midwifery courses were organised slightly differently in Glasgow, where control was also transferred to medical men.[132] However, in Aberdeen such classes were organised by the Kirk Session, presumably to retain its control over the rite of birth, and taught by a local doctor. From 1826-31, a scheme to 'examine and grant certificates to midwives' from the city and country parishes, was administered by a committee of the Aberdeen Medico-Chirurgical Society.[133]

The overall impression is that in Scotland, such lecture courses were popular with midwives, who appear to have accepted without question the benefits of teaching by a medical man. Indeed, whilst the male domination of midwifery implied by such courses was questioned by some of their contemporaries, notably Elizabeth Nihell,[134] it has seldom been so by midwifery historians, who have focused on the recognition of midwifery implied by such courses. The general acceptance of such lecture courses also suggests that by then emphasis was placed on the medical rather than the cultural aspects of birth. The Edinburgh courses were undoubtedly popular: Professor James Hamilton claimed in 1817 that over a thousand midwives had been trained in Edinburgh since 1780.[135]

The content of such courses is less known.[136] Young's course on midwifery for medical students consisted of 50 lectures, plus some practical experience.[137]

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[132] From 1740 midwives were licensed after examination by the Faculty of Physicians and Surgeons, and fined for practising without a licence. From 1761, independent lectures in midwifery were given by James Muir, and this continued under James Towers, who established the first lying-in hospital and became professor in 1815. (Derek A. Dow *The Rottenrow* (Carnforth: the Parthenon Press, 1984), pp. 142-3; Elspeth King *The Hidden History of Glasgow's Women: The Thenew Factor* (Edinburgh: Mainstream, 1993), p. 55).

[133] G. P. Milne, 'History of Midwifery in 18th, 19th and early 20th century Aberdeen', *Medical History* 22 (1978), pp. 205-6; Jacqueline Jenkinson *Scottish Medical Societies* (Edinburgh: Edinburgh University Press, 1993), pp. 82-3.

[134] Towler and Bramall, *Midwives in History and Society*, pp. 104-6.

[135] Donnison, *Midwives and Medical Men*, p. 50: she is quoting Hamilton's *A Letter to Sir William G....*

[136] Wilson has suggested that the content of London courses could vary greatly, according to the convictions of the lecturer: some advocated intervention, whilst others followed a strictly natural approach. This interpretation of the changes in midwifery in the eighteenth century has been questioned by Loudon, and in Scotland lecturers appear to have adopted a uniform outlook. (Adrian Wilson *The Making of Man-Midwifery: Childbirth in England 1660-1770* (London: UCL Press,

1881. This sought to develop a new profession, defined by a common body of knowledge (and initially examined by the London Obstetrical Society), and a common attitude, whilst using the old job title. Thus, any pre-existing midwifery training tended to be condemned by the registration movement as suitable only for training monthly or maternity nurses, a situation compounded by the existence of courses which did precisely that, and the manner in which trained midwives worked as both midwives and maternity nurses.[142] The reformers also focused on developments in London, and took less interest in those in the provinces. Nonetheless, there is evidence of local midwifery training throughout Britain during the nineteenth century, including some presented to the 1892 Select Committee on Midwives' Registration.[143]

However, the lack of a registration requirement for midwives until the early twentieth century means there is much less information available about the backgrounds or future career of midwives trained at the ERMH, although this is the group for whom hospital experience, expectations and employment changed the most in the period under study. The early Rules describe two categories of female pupil, '[w]omen intending to become monthly nurses or nursery-maids', who attended daily and were taught by the matron,[144] for whom there is no additional evidence until 1909,[145] and midwives, attending doctors' lectures elsewhere and supervised by the house surgeon. These were 'admissible to the in-practice of the hospital ... in classes which shall contain no more than three in each'. Again their entry to the wards was

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[142] Towler and Bramall, *Midwives in History and Society*, pp. 146-51; Leap and Hunter, *The Midwife's Tale*, p. 69; in the 1851 census record for the ERMH, Mrs. Barbara McGregor described herself as 'Midwife and Ladies' Nurse' (Carstairs, *Edinburgh 1851 Census*, Volume I, *The Canongate*, p. 279).

[143] P.P., *Report of the Select Committee on Midwives' Registration*, 1892 (289) XIV, pp. 1-173, Evidence of R. R. Rentoul M.D., q:378; Evidence of Mr George D. D. Thomas, M.D., Coroner for London, q:1597; Evidence of Mr Francis Rowland Humphreys, qq:981-984; Evidence of Dr James Aveling, q:300; Evidence of Dr James Edmunds, Medical Officer of Health for St. James's, Westminster, q:1439; Evidence of Dr Leslie Drage, q:772. In addition, the London General Lying-in Hospital also continued to train midwives, as did the Royal Maternity Charity. (Philip Rhodes *Doctor Leake's Hospital – a History of the General Lying-In Hospital, York Road, Lambeth 1765-1971* (London: Davis Poynter Ltd., 1977), pp. 152-75; Stanley A. Seligman, 'The Royal Maternity Charity: the First Hundred Years', *Medical History*, 24 (1980), pp. 403-18).

[144] *Rules and Bye-Laws*, 'Female Pupils', Rule 1.

[145] In 1909 monthly nurse pupils were charged 13gns, but the directors intended ending the course subject to Medical Board approval. (DMERMH, 25 April 1910).

by invitation of the house surgeon or the Matron.[146] When considered fully instructed, they received a certificate of qualification signed by the house surgeon and an Ordinary Medical Officer.[147] There is no evidence of specific hospital certificates prior to 1872, when these were ordered from the printer.[148] However, separate lecture courses in midwifery continued throughout the period under study, and a number of signed certificates for these do survive, the earliest extant being that of Mrs. Robertson in 1848.[149] In 1903, having adjusted its nurse training, the ERMH applied to the new Central Midwives' Board [CMB] for inspection and approval, and this was granted.[150] Previously-trained nurses now attended for four months, at a charge of 15 gns, whilst untrained women were charged 21 gns for a six-month course, each incorporating doctors' lecture fees of 4 gns and 6 gns respectively.[151] This was an increase on the earlier fees charged. In February 1878 Nurse Elizabeth Brown had paid for her three months' training, 4 gns in lecturer's fees, 10s. 6d. to the hospital, and £6 10s. for board and lodging, giving a total outlay of £11 4s. 6d.[152] There was a wide variation in the midwife's potential earnings in the second half of the nineteenth century, which makes assessment of their investment in training difficult. Mrs. Lawson, who attended John Inglis' wife in 1879, was paid 15s and her keep for a period described by Inglis' editor as ten days, but which, from the diary, was approximately a month; the Edinburgh-trained monthly nurse who attended Princess Christian charged her well-connected clients between 10 and 25 gns.[153]

There is little direct evidence from the ERMH of formal instruction for pupils from qualified nurses or midwives as opposed to doctors in the period under study, although this is not to say that there was none: in 1910, Jessie Cuthbert heard lectures

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[146] *Rules and Bye-Laws,* 'Female Pupils', Rule 4. A hospital entry ticket issued in 1848 to Mrs Robertson, midwife, is extant. (Papers of Mrs. Margaret Robertson, photocopies sent from Otago of her diploma, ticket of admission and two testimonials [LHSA, LHB MAC GD 1/27/1-3]).
[147] *Rules and Bye-Laws,* 'Female Pupils', Rule 5.
[148] The year ending accounts 1872-3 include, 'to A. & K. Johnston, for Nurses certificates' DMERMH, 13 March, 1874).
[149] The issue of separate lecture certificates ceased in July 1894 under pressure from the GMC.
[150] DMERMH, 22 April, 1902, 14 December 1903.
[151] DMERMH, 17 March 1909.
[152] ERMH Cash Book, 1876-1889. In the early period monthly nurses also paid 10s.6d. for their unspecified time at the hospital. (*Rules and Bye-Laws,* 'Female Pupils', Rule 3 (monthly nurses); Rule 6 (midwives)).

from the matron at the ELII. In 1889, when Alexander Simpson was trying to have university lecturers appointed to staff posts at the ERMH, he suggested that 'the senior and the 2° Assistant Physician might have the nurses class during the winter and spring quarters'.[154] This implies that the nurses' lectures and their practical experience were no longer completely separate, but that both were associated with the hospital. Prior to 1892, when the new Matron began a formal Register of Nurses that listed each class by name, with some background information, there is only a little evidence of classes outwith casebook analysis, either from annual reports, or from cashbooks. However, the hospital's increasing dependence on its female pupils for patient care is shown by an incident in 1879, when the nurses were given their certificates early, and left before they should: 'consequently there were not sufficient Nurses to carry on the work satisfactorily'.[155]

Unlike medical students, female pupils were not reminded of their behaviour towards their patients, but their attitude towards the house surgeons and matron was to be 'respectful and obedient', and they were 'on no occasion, [to] carry spirits or other liquor into the Hospital' on pain of dismissal.[156] Both injunctions show the expectations and prejudices of those who drew up the Rules. However, annual reports repeatedly stress the usefulness of the nurses, and sometimes provide other information on their origins. Between 1884 and 1893, these were published in the ERMH annual reports. In 1893 only 62.5% of nurses were Scots, by no means always from the Edinburgh area, whilst 31% were English.

2.6 The Management of Natural Labour and Delivery

This section explores the management of a conventional natural labour and delivery in the second half of the nineteenth and early twentieth century, to provide the context in which hospital and dispensary births took place. The principal sources are

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[153] Inglis, *A Victorian Edinburgh Diary*, p. 35; D. Baird *Victorian Days and a Royal Friendship* (Worcester: The Worcester Press, 1958), p. 101.
[154] DMERMH, 7 February 1889.
[155] MBMERMH, 1 April 1879.
[156] *Rules and Bye-Laws,* 'Female Pupils', Rule 7.

the detailed lectures given by Simpson to his medical students in 1850-1,[157] intended to prepare them for private practice, and the notebooks of Jessie Cuthbert, a pupil midwife who attended the ELII in 1910.[158] Presumably in her case the lectures were both to prepare her for later work, and to tell her how to manage the dispensary cases she was attending at the time.

During the nineteenth century, almost all births took place in the non-medical environment of the mother's home, and the attendance at a birth depended on the wishes of the expectant mother, her attitudes, and the budget available to her, as described in Section 2.3. Angus Macdonald, lecturing 'for the People' in Edinburgh in the winter of 1880-1, could merely advise that '[a]t her delivery every woman needs medical care and nursing'.[159] However, the presence of family, often including the husband or close female friends, seems to be common to all accounts of birth. Only dispensary and Indoor patients normally exchanged the right to choose their attendant for that of potential free access to highly qualified medical care if necessary.

Throughout the nineteenth century, when a doctor was engaged, he remained subject to the expectant mother's demands, and her decision could be swayed by the other people present. This attitude is clearly illustrated by recent analyses of the letters of aristocratic and upper middle-class ladies. These provide the data for both Patricia Jalland's and Judith Schneid Lewis's accounts of nineteenth-century confinement in Britain, and for Judith Walzer Leavitt's study of childbirth in America, and, incidentally, for much of the objective information available on the management of normal childbirth in the period.[160] Other accounts suggest working-class mothers also maintained their autonomy. In 1850s New York a Dispensary patient rejected the

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[157] Heads of Lectures on Midwifery etc. Delivered by J. Y. Simpson M.D. Professor of Midwifery in the University of Edinburgh; with Remarks collated from notes taken by George Mackay M.D. during the Winter Session 1850-1 [LHSA, LHB MAC GD1/1/4A & B 2 vols.]

[158] Lecture Notes of Jessie Inglis Cuthbert [LHSA, LHB MAC GD1/13/1].

[159] Edinburgh Health Society *Health Lectures for the People 1880-1* (Edinburgh: 1883), p. 130. Angus Macdonald was one of four ordinary physicians at the ERMH at the time.

[160] Patricia Jalland *Women, Marriage and Politics 1860-1914* (Oxford: Clarendon Press, 1986), pt.2, pp.131-185; Judith Schneid Lewis *In the Family Way: Childbearing in the British Aristocracy 1760-*

medical officer's advice to submit to craniotomy, and insisted that his Roman Catholic senior be called, to deliver her child intact, whilst in Australia one mother rejected the midwife's advice to call the doctor on the grounds of expense, and, when this was over-ruled, his proposed method of delivery.[161] Although doctors resented the intrusions of well-meaning relations, and the limitations they placed on their practice,[162] they accepted the need to conform if they wished to prosper in business.

Within the home, the place of delivery also depended on the money available. The aristocrats of whom Lewis wrote reserved a suite of rooms for the occasion, and the women of the family appear to have had a designated delivery bed, which was moved from home to home as necessary. Simpson described his ideal situation for birth to his students. Again there was to be a dedicated lying-in room, with an obstetric bed, an adjacent sitting room, ostensibly for use by the mother 'when able to move',[163] and good ventilation. Jessie Cuthbert's lecture notes give a detailed description of the 1910 ideal. 'When possible ... a quiet & well-ventilated room, free from sewage gas', was to be selected, with an open fire, fresh air through an open window, and hot water to hand.[164] In reality, all attendants had to manage with the circumstances available. Detailed evidence of the delivery scene in nineteenth century institutions is limited. European critics of lying-in hospitals, and proponents of sanitary medicine, spoke of gross over-crowding in such institutions.[165] However, Quiroga notes that the women organisers of the New York Asylum for Lying-In Women in the 1820s provided a domestic childbed experience for the destitute but married women who attended.[166] From its inception in 1858, patients at the Royal Women's Hospital in Melbourne, which was based on Simpson's ideal of hospital

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1860 (New Jersey: Rutgers University Press, 1986); Judith Walzer Leavitt *Brought to Bed: Child-bearing in America 1750-1950* (New York: Oxford University Press, 1986).

[161] Frank M. C. Forster, 'Mrs. Howlett and Dr Jenkins: Listerism and early midwifery practice in Australia', *The Medical Journal of Australia*, I No.26, 1965, pp. 1047-54; Virginia Anne Metaxas Quiroga, 'Poor Mothers and Babies: a Social History of Childbirth and Childcare Institutions in Nineteenth Century New York City' (Ph.D. Thesis, State University of New York at Stony Brook: Department of History, 1984), pp. 72-4.

[162] From the experiences of Dr H. B. Willard, the use of opium, ergot, and artificial rupture of membranes was acceptable, but emetics and forceps were not. (Leavitt, *Brought to Bed*, p. 48).

[163] Mackay, Heads of Lectures, Vol.1, p. 140.

[164] Cuthbert, Lecture Notes, Lecture 15 (Matron), 10 June 1910.

[165] Jenny Carter and Thérèse Duriez *With Child: Birth through the Ages* (Edinburgh: Mainstream Publishing, 1986), p. 45.

design, delivered in single rooms, accompanied only by hospital staff. Unusually, they were then nursed alone in these rooms for the first nine days, before moving to the communal ward. [167]

In direct contrast to much modern labour ward practice, once labour had commenced, the expectant mother was encouraged to stay on her feet for as long as possible. Simpson noted that the 'additional advantage of the Child's weight ... is lost if she is recumbent'.[168] Sixty years later Jessie Cuthbert was told '[i]t is usually best to keep patient alternately walking or sitting in order that the weight of the foetus may assist ... by force of gravity'.[169] Although Simpson advised that the medical attendant should go to his case as soon as he was summoned, during the first stage his role was limited to obtaining information about the position of the child. For this he used a history of its movements, auscultation, and a careful vaginal examination to determine both the presenting part and its position, and the progress of labour. Once his initial examination was complete, Simpson himself made use of the sitting room suggested above to work on his various papers, usually unconnected with the current case.[170] The doctor who attended John Inglis' wife in 1879, having carried out his initial examination, left, to return when fetched by Inglis many hours later.[171] The nurse was expected to maintain communication between doctor and patient, to keep the patient's morale up and her bowels and bladder empty. As sole attendant, Jessie Cuthbert had to carry out all the above duties, and was given no guidance on when or whether she might leave a case to which she had been summoned.

Once the second stage was thought to have begun, and was confirmed by vaginal examination, Simpson recommended a number of treatments to relieve the more painful symptoms of the descent of the head, such as cramp, or rigors, which he

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[166] Quiroga, 'Poor Mothers and Babies', pp. 47-78.
[167] Janet McCalman *Sex and Suffering: Women's Health and a Women's Hospital* (Baltimore: Johns Hopkins University Press, 1998) p. 14.
[168] Mackay, Heads of Lectures, Vol.1, p. 137.
[169] Cuthbert, Lecture Notes, Lecture 15 (Matron), 10 June 1910.
[170] Mackay, Heads of Lectures, Vol.1, p. 140.
[171] Inglis, *A Victorian Edinburgh Diary*, 28 April 1879.

believed were related to its position. He suggested chloroform only if the nurse reported 'great pain'.[172] Gélis has described the position of the mother in labour and delivery as partly a cultural and partly a physical response. He notes that in eighteenth-century France some positions were discouraged by medical men.[173] It is evident from nineteenth-century Scottish material that the position adopted by the mother at delivery became increasingly a medical decision. Simpson acknowledged, and did not condemn, the use of 'knees and elbows' and 'the lap of a friend' as delivery positions. However, he did advocate delivery in the left-lateral position, if permitted, to his students.[174] By 1910, Jessie Cuthbert's patients were expected to deliver in the left-lateral position to avoid tearing.[175] In a further acknowledgement of traditional childbirth practice, Simpson recommended offering the new mother a heated stimulant immediately after delivery, to avoid a rigor. According to both Simpson and Cuthbert's notes, a normal second stage was expected to last 2 to 3 hours in a parous patient, 2 to 4 in a primigravida.

In his lectures, Simpson describes William Hunter's determination to leave the third stage to nature, a view that eventually, he notes, Hunter was forced to moderate. However, Simpson does recommend that 'the exciting cause which induces contraction of the uterus and causes it to expell [sic] the placenta' be maintained if possible.[176] Should contractions not return in 10-20 minutes, and the placenta be lying in the vagina, then it should be extracted. If not, the return of contractions should be encouraged by 'pinching' the uterus, and, after an hour, controlled cord traction used. Blood loss should be monitored throughout. Pads and a binder were then applied, but Simpson expected the attendant to remain for a further hour, in case of haemorrhage. The patient should be left horizontal and calm, and this should be stressed to the friends.[177] By 1910, it was considered a cause for concern if the placenta had not been delivered after 45 minutes. The midwife's duties at this stage

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[172] Mackay, Heads of Lectures, Vol.1, pp.140, 148, 150.
[173] Jacques Gélis (trans. R. Morris) *A History of Childbirth: Fertility, Pregnancy and Birth in Early Modern Europe* (Cambridge: Polity Press, 1991), p. 124.
[174] Mackay, Heads of Lectures, Vol.1, p. 144.
[175] 'It is the duty of the midwife to watch over the vulva, while the head is extending, & to prevent rupture of the perineum.' (Cuthbert, Lecture notes, Lecture 15 (Matron), 10 June 1910).
[176] Mackay, Heads of Lectures, Vol.1, p. 150.

not only included staying, but also offering 'a little nourishment, egg & milk just warm', taking the mother's temperature and pulse, burning the placenta after examining it for completeness, and removing the soiled linen.[178]

Simpson described the puerperium to his audience as 'the most anxious part of it', and dealt with a large number of potential problems, especially the distinctions between the various puerperal febrile states.[179] However, he gave very few instructions about mobilisation or diet: presumably this was the nurse's area of expertise. Once their child was born, John and Teen Inglis, mentioned above, did not see Dr Moir again, but the nurse lived in their house with them, apparently leaving the new parents alone with their son for part of the evening for the first time when he was a fortnight old. By this time Teen had 'appeared in the parlour' for two days, and been up for part of the day for a week. When their son was 18 days old, John recorded '[a] drive with Teen in a cab, she going out for the first time'.[180]

The timing of a mother first getting up after childbirth became increasingly significant as middle-class women became interested in the recovery of their working-class sisters after delivery. Many correspondents to *Maternity* felt their domestic circumstances had forced them to mobilise before they had recovered.[181] Although Jalland's correspondents largely ignored or criticised their doctors' instructions during pregnancy, this was one area where medical advice was followed, apparently due to an extreme fear of uterine prolapse, for which there was no effective cure.[182] Proper nursing and rest after delivery, even when the mother felt well, formed the main part of the advice on childbirth given by Macdonald. He saw this as a problem for 'the wives of our working men ... [who] ... as they frequently feel pretty well ... think that they should at once be up and attending to their

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[177] Mackay, Heads of Lectures, Vol.1, pp. 151-3.
[178] Cuthbert, Lecture Notes, Lecture 15 (Matron), 10 June 1910.
[179] Mackay, Heads of Lectures, Vol.2, pp. 152-216.
[180] Inglis, *A Victorian Edinburgh Diary* 6 May 1879-17 May 1879.
[181] Women's Co-operative Guild *Maternity: Letters from Working Women collected by the Women's Co-operative Guild* (London: G. Bell & Sons Ltd. 1915). See particularly Letter 132: 'I can only look back on the terrible suffering I have endured, that tells a tale now upon my health. I could never afford a nurse, and so was a day or two after my confinements obliged to sit up and wash and dress the others'.

household duties'. He urged them: '[d]on't heed the common delusion that a patient ought to be able to get up on the ninth day'. He believed early rising caused premature ageing and uterine problems.[183] This was an area where medicalisation of childbirth was successfully encouraged through the combination of medical advice and the personal experience of its supporters.

However, as with position at delivery, the Scottish evidence suggests that there was also a cultural aspect to the timing of first rising. Nan Courtney (born c.1913), interviewed for the School of Scottish Studies in 1991, described the puerperal experiences of her Ayrshire-born grandmother in Glasgow. Having given birth in the night, to the astonishment of her neighbours she was up and about her normal duties in the day. She 'swore she never lay a day in bed wi one ...'.[184] This story suggests that the formal lying-in period, described in accounts of early modern midwifery, was by no means universal.[185] However, in Edinburgh, Jessie Cuthbert was advised to nurse her patients prone for the first fortnight, apparently for fear of pulmonary embolism and retroversion. Laudanum drops or 'opium tabloids' were recommended for afterpains. The vital signs were to be recorded daily, and the degree of involution, and the nature of the lochia, noted. If it appeared infected, medical aid was to be sought.[186] Both Simpson and Matthews Duncan[187] devoted lecture-time to the establishment of breast-feeding, breast problems, and, in Simpson's case, the selection of a wet-nurse should it prove necessary.[188] In 1910 Jessie Cuthbert received one lecture each on breast- and bottle-feeding.

Thus it can be seen that where there were no complicating factors, and the foetus adopted a cephalic presentation (estimated to be between 93% and 95% of births), in

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[182] Jalland, *Women, Marriage and Politics*, pp. 152-3.
[183] Edinburgh Health Society, *Health Lectures*, p. 130.
[184] Margaret Bennett *Scottish Customs from the Cradle to the Grave* (Edinburgh: Polygon, 1992), p. 44.
[185] Wilson, *The Making of Man-Midwifery*, pp. 26-30, 205-6. See also the attitude to first rising after birth described in Martha Ballard's diary, when early rising is seen as a sign of health (Laurel Thatcher Ulrich *A Midwife's Tale: The Life of Martha Ballard, Based on Her Diary, 1785-1812* (New York: Vintage Books, 1990), pp. 189-90.
[186] Cuthbert, Lecture Notes, Lecture 13 (Matron), 30 May 1910.
[187] James Matthews Duncan, 'Lecture Notes taken by John Playfair, 1871-2' (Royal College of Physicians of Edinburgh Library). The lectures for 12 –14 March cover breast-feeding.

the nineteenth century the actual medical requirements of the attendant in labour were small. However, when there were problems, diagnosis was problematic: many problems were recognised only when they became emergencies, and this not only by doctors and midwives. Many patients adopted a fatalistic (or realistic) stance when problems first occurred, and failed to seek medical advice. For example, Eccles notes that slow ante-partum haemorrhage was largely ignored by patients in the seventeenth century, an attitude that the ERMH data suggest continued into the nineteenth, although the subsequent anaemia could affect recovery.[189] Heavy reliance was necessarily placed by the doctor on the history given by the patient, as physical examination affronted so many social norms that it was kept to a minimum. Radcliffe believes routine abdominal palpation to ascertain lie and presentation to be a twentieth-century tool:[190] he may well be right as regards private practice, although the technique was in use on charity patients at the ERMH in the 1870s. Jalland notes that the first reference to an antenatal internal examination amongst her correspondents is in 1895, and to palpation in 1905.[191] Equally, listening to the fetal heart through a stethoscope was generally deplored in the early nineteenth century,[192] although Simpson described it to his students as a guide to fetal position.[193] Vaginal examination was entirely conducted by touch, with the external genitalia covered by a sheet at all times, and was usually only permitted once labour had begun.[194] Jessie Cuthbert, admittedly only intending to deliver normal cases, was advised only 'to suggest a vaginal examination' although she was expected to use some palpation.[195] With the exception of the mechanical difficulty represented by a history of contracted pelvis, there was little attempt to forecast potential obstetric or health problems.

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[188] Mackay, Heads of Lectures, Vol.2, pp. 217-30.
[189] Audrey Eccles *Obstetrics and Gynaecology in Tudor and Stuart England* (London: Croom Helm, 1982), p. 126.
[190] Walter Radcliffe *Milestones in Midwifery* (Bristol: John Wright & Sons, 1967), pp. 91-2.
[191] Jalland, *Women, Marriage and Politics*, p. 141-2.
[192] Carter and Duriez, *With Child*, pp. 50-1. Professor James Hamilton (Simpson's predecessor) thought the practice 'would be indignantly rejected by every practitioner ... of reputed respectability', whilst in the 1860s Francis Ramsbotham still dismissed it, as 'he had no personal experience'.
[193] Mackay, Heads of Lectures, Vol.1, p. 124.
[194] Carter and Duriez, *With Child*, p. 49.
[195] Cuthbert, Lecture Notes; Lectures 6 and 8.

Without statistical data on delivery outcomes the recognition of more complex problems in labour was difficult: the casebooks of the ERMH were probably intended to supply this information. There was continued controversy over what constituted a problem, most clearly seen in the debate over 'tedious' or 'lingering' labour; that is, labour unlikely to be completed within 24 hours, although the fetus still presented by the head. Possibly as a result of differing practice in timing labour, mid-nineteenth-century doctors were not convinced that prolonged labour *per se* was harmful to either mother or child. Simpson believed that it was.[196] Matthews Duncan disputed this, although he did concede that some of the danger lay in the repeated vaginal examinations such a patient would undergo.[197] The actual treatment available when labour or delivery was problematic will be discussed in Chapter 4.

2.7 Conclusion

Placing the ERMH in context indicates a number of themes that will be explored in the following chapters. Its background and early history suggest that it was principally a charity, and not even a popular one. As such it had little in common with mid-twentieth-century maternity hospitals. However, it also had an educational role that became associated with increasing professionalisation among its senior doctors, and in many ways its early history can be seen as one of tension between its two functions. Despite the apparent unpopularity of its Indoor regime, as a result of the expansion of medical education in Edinburgh it became closely involved in the medicalisation of childbirth. The following chapters use material principally drawn from the ERMH casebooks to explore the hospital's development and contribution to an increasing medical role in childbirth among the poor, and their acceptance of that role.

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[196] James Young Simpson *Two Letters to Dr Collins, President of the King & Queen's College of Physicians of Ireland etc. I. On the duration of labour as a cause of mortality and danger to the mother and child* (Edinburgh: Sutherland & Knox, 1848); Mackay, Heads of Lectures, pp. 226-30.
[197] James Matthews Duncan, *On the Mortality of Childbed and Maternity Hospitals* (Edinburgh: Adam and Charles Black, 1870), pp. 68-87.

Chapter 3

Indoor and Outdoor Patients at the Edinburgh Royal Maternity Hospital, 1844-1914

3.1 Introduction

This chapter examines the patients of the Edinburgh Royal Maternity Hospital [ERMH] in the belief that their selection of the hospital, and its selection of them, provides insight into its nature and rationale. This is particularly so at a period when the vast majority of births in Scotland had no institutional input, but occurred in the mother's home, attended by either family members, a doctor and monthly nurse, or a midwife with family support, all attendants being selected and retained by the family. In contrast to our own time, when arguments rage over the degree of medical involvement, medical attendance in any form was far from mandatory. As an urban example, in April 1898 Miss J. Paton D.C.S., who acted as a District Nurse from the Deaconess Hospital, visited Mrs Simmonds in South Richmond Street, for 'Phthisis/ Maternity/ nursing/ sent by Dr. Paterson', but the '[b]irth [had been] attended by Mother ...'.[1] Equally, writing about his rural childhood in South Harris in the 1920s, Finlay J. Macdonald observes that to deliver her daughter's first child was the prerogative of her mother, although later family additions were left to the District Nurse.[2]

Historians' approach to the inmates of maternity hospitals has been varied. For example, Philip Rhodes, in common with other earlier authors of institutional histories, sees the inmates of 'his' institution, the General Lying-In Hospital, Lambeth, as passive and hardly-mentioned recipients of care.[3] More recently, both Janet McCalman and Jürgen Schlumbohm have examined in great detail the patients

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[1] Lothian Health Services Archive [LHSA], District Nursing Case Book, Deaconess Hospital 1896-1915, 12 April 1898.
[2] Finlay J. Macdonald *Crowdie and Cream: Memoirs of a Hebridean Childhood* (London: McDonald & Co., 1982; Futura, 1983), p. 157.

of, respectively, the Royal Women's Hospital, Melbourne, and the Lying-In Hospital of Göttingen University, but ultimately they also present them as passive illustrations of the establishment's work.[4] Ian Campbell Ross presents the eighteenth-century patients of the Rotunda similarly, using them to illustrate its charitable role rather than any obstetric function.[5] However, based on her work on nineteenth-century maternity institutions in New York, Virginia Quiroga has argued that patients' behaviour and acceptance (or not) of treatment offered, shaped the institution concerned.[6] This chapter argues that detailed examination of patient records can be employed to show the changing nature of an institution over time, specifically the Edinburgh Royal Maternity Hospital [ERMH], and that patients' recorded behaviour shows their expectations of a hospital, be they charitable or medical.

Sources on the Indoor patients of the ERMH come in two main forms, the Births Register, which contains principally social data, and the casebooks. These also take two forms, those which record the routine medical details of delivery of all patients (Indoor Casebooks), and those in which selected cases are described in greater detail (Special and Ordinary Casebooks). The linking of these records at an individual level has made detailed examination of the hospital population possible. The Outdoor casebooks are the only source for patients delivered in their own homes, although a small number of individuals have been traced in the Edinburgh Census of the following year.

Using both individual case histories and whole year patient data, this chapter establishes that, until the early twentieth century, married Indoor patients who used

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[3] Philip Rhodes *Doctor Leake's Hospital – a History of The General Lying-in Hospital, York Road, Lambeth 1765-1971* (London: Davis Poynter Ltd., 1977).
[4] Janet McCalman *Sex and Suffering – Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856-1996* (Melbourne: Melbourne University Press, 1998); Jürgen Schlumbohm, ' "The Pregnant Women are Here for the Sake of the Teaching Institution": the Lying-In Hospital of Göttingen University, 1751-c.1830', *Social History of Medicine*, 14 No. 1, 2001, pp. 59-78.
[5] Ian Campbell Ross, 'The Early Years of the Dublin Lying-in Hospital' in Ian Campbell Ross (ed.) *Public Virtue, Public Love: The Early Years of the Dublin Lying-in Hospital – the Rotunda* (Dublin: the O'Brien Press, 1986), pp. 32-4.
[6] Virginia Anne Metaxas Quiroga, 'Poor Mothers and Babies: a Social History of Childbirth and Childcare Institutions in Nineteenth Century New York City' (Ph.D. Thesis, State University of New York at Stony Brook: Department of History, 1984).

the ERMH were atypical of the childbearing population, and that before the twentieth century those who can definitely be identified as attending for obstetric care were in a very small minority. This in turn indicates that until that time, the hospital was seen by its in-patients as a provider of social shelter rather than of medical expertise. However, the data from 1890 show that, by then, Outdoor married patients were typical of the childbearing population as a whole in age (though not in parity), suggesting that the ERMH was more successful in taking maternity care out to poor patients in their own homes. Single Indoor patients, who were in the majority until approximately 1912, have also been examined. This chapter suggests that they continued to see the ERMH as a shelter, although towards the end of the period studied, the hospital's social role may have been moving to the emerging 'mother and baby' homes, whilst its medical function expanded. Additionally, this chapter suggests that the ERMH's single patients were caught up in changing attitudes to marriage and illegitimacy.

This chapter first examines individual aspects of the social data, such as marital status, age, parity, origins and current residence, and compares these with available national data collected on the general childbearing population of Scotland in 1855, to see if the ERMH patients were typical. Thereafter several features of the patient group are combined to give a better understanding of their purpose in attending the hospital. The patients' general response to the hospital is also examined, although aspects of patient life which relate to their medical treatment by the ERMH are discussed in Chapter 4 rather than here.

3.2 General Data on the Indoor and Outdoor Patients of the ERMH, 1850-1912

The ERMH had two different populations, those who used its Dispensary, who were nearer to the common practice of the time in that they did deliver at home, and those who elected to be Indoor patients. Addressing the 1843 Commission on the Poor Law in Scotland, Alexander Ziegler, the Ordinary Surgeon at the hospital, made little distinction between the two groups in terms of accommodation and poverty, and

proceeded to focus on the circumstances of Indoor patients.[7] However, the examination of their age, parity, origins, current residence and marital status in this chapter suggests that there were differences and that these may have influenced their decision whether to use the hospital or the dispensary.

3.2.1 Marital Status

Knowledge of their marital status is important in understanding the intentions of all ERMH patients. In 1850 and 1870, in the case of Indoor patients, it was recorded as a response to a direct question.[8] By 1890 the layout of the Births Register had changed, and marital status was no longer recorded directly. However, it can still be deduced, as the mother's occupation was recorded if the child were illegitimate, whilst the same column held the father's name and occupation if she were married. The year of marriage was also recorded from this date. As can be seen from Figure 3.1, single women predominated among the Indoor patients until the early twentieth century. In each year studied, a small number of patients tried to deceive the recorder as to their marital status.[9]

Identification of marital status for Outdoor patients is much less satisfactory. It can be deduced only from the use of the title 'Mrs', or by finding the patient in the census for the following year.[10] It is also evident that the Scots custom of continuing to use the woman's maiden name as well as her married title continued in Leith, if not Edinburgh, into the twentieth century. The 1912 Students' External Casebook (Leith Branch) used both maiden and married names for 82.3% of its married clients (96.5% of the whole), in the form 'Kate Lynch, Mrs Campbell', or 'Kate Lynch or

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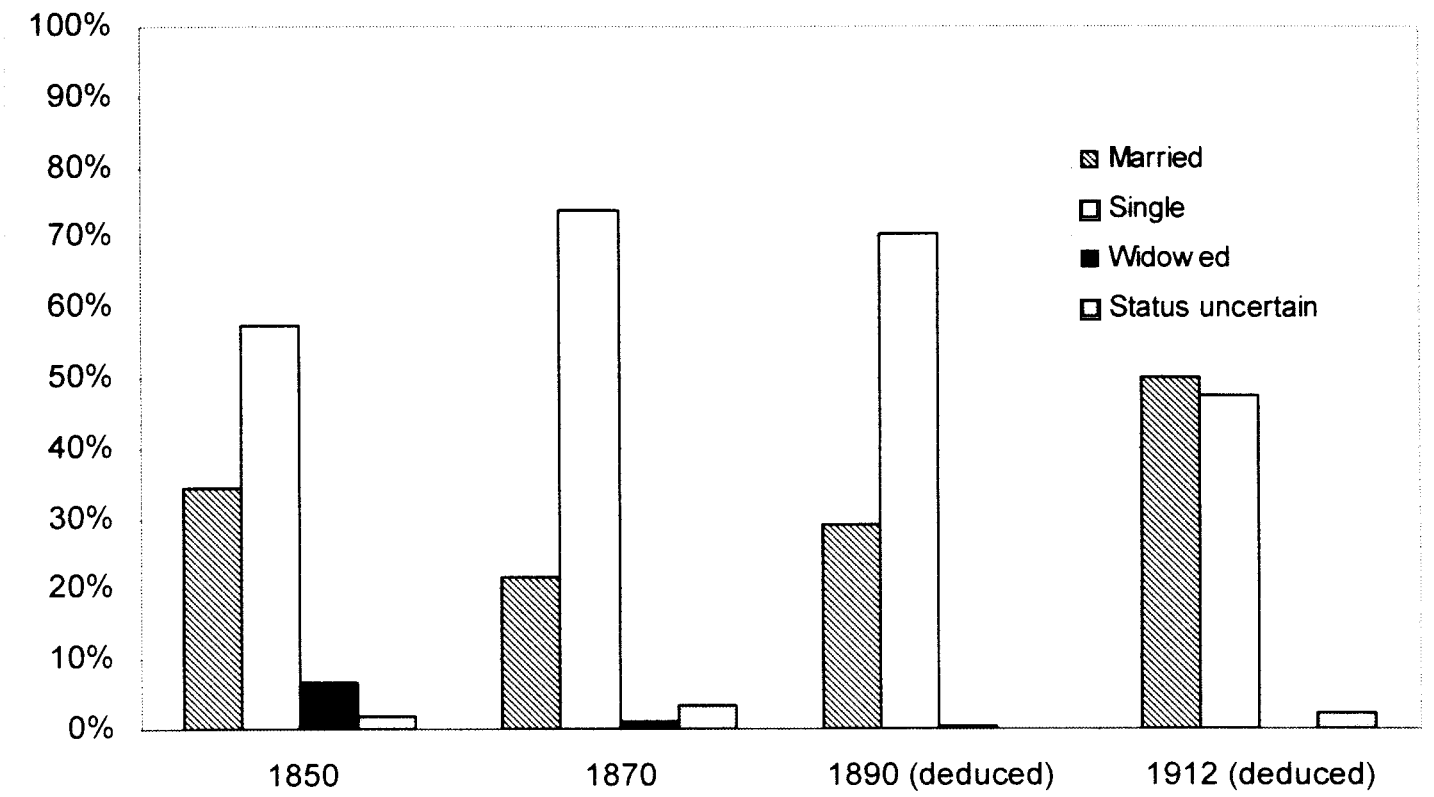
[7] Parliamentary Papers [P.P.], *Report from Her Majesty's Commissioners for Enquiring into the Administration and Practical Operation of the Poor Laws of Scotland,* 1844 (563) XX, evidence of Mr. Alexander Ziegler, qq: 2594-2616.

[8] In 1850 the marital status of Indoor patients was unambiguously recorded in 91.8% of cases. In 1870 marital status Indoors was clearly recorded in 96.7% of cases. In 1890, in the new Births Register, occupations were recorded for either mothers or fathers in all cases. 29.3% of Indoor cases were married, and there were two widows. 70.4% were single. However, by 1912 50% of Indoor Patients were married, whilst 47.5% were single. There was one widow.

[9] See, for example, 1912 Indoor Casebook [ICB], case 134 (Prof. Halliday Croom's quarter) [JHC] [602/134/hc/1912i]. Typically, 'un' has been added to 'married' in their record.

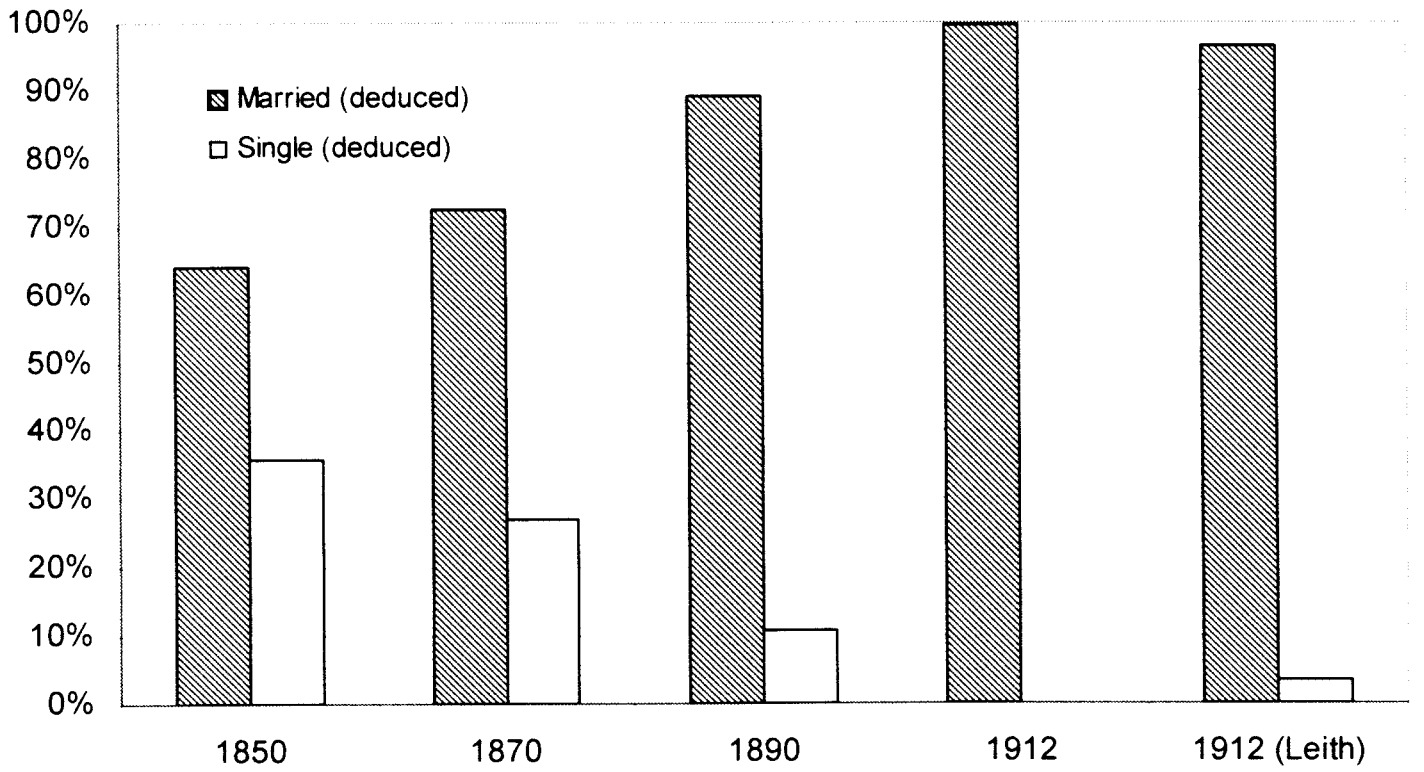
[10] 'Miss' was not used in the records.

Figure 3.1
Marital Status of Indoor Patients at the ERMH, 1850-1912



Source: ERMH Births Registers for 1850, 1870, 1890, 1912.

Figure 3.2
Marital Status of Outdoor Patients of the ERMH, 1850-1912



Source: ERMH Outdoor Casebooks, 1850, 1870, 1890; Students' External Casebooks (main dispensary and Leith Branch), 1912

Campbell'.[11] However, when the technique of considering only those given the title 'Mrs' as married is applied to earlier Outdoor casebooks, it does yield a very high proportion of apparently illegitimate births, as shown in Figure 3.2. Only the 1890 Outdoor casebook gives a percentage close to the national figure for illegitimate live births for that year, that is, 8% in 1886-90, whilst the Outdoor ERMH figure of 1.6% in 1912 is well below the national rate of 7.2% in 1911-15.[12] The 1890 casebook was largely completed by one person in each quarter-year, as opposed to the multiple recorders of earlier years, which may have predisposed to greater care; however, the external casebooks of 1912 had multiple recorders, the nurses who attended the cases.

In addition, census evidence also suggests that using the Outdoor casebooks to deduce marital status is fraught. For example, in March 1870, Anne Bagan, 24, gave birth to her third child at 5 College Wynd. In 1871 the Census recorded a Mrs Ann Clark, wife of Patrick Clark, aged 25, with two children, the younger aged one year, living at that address, very probably the same person.[13] Overall, the evidence suggests that in the earlier years of this study, Outdoor figures for married women deduced from title alone are likely to be too low, although they still greatly exceed those for Indoor patients.

However, there is an alternative explanation for such a sizeable body of single women as Outdoor patients. James Stark, writing on illegitimacy in the 1861 census, described a category of single women who could, quite plausibly, have used the ERMH dispensary.

> Investigations showed that ... the parents of these illegitimate children were true to each other, that the woman had borne several children to the same man, and that frequently the children were legitimized by the

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[11] Interestingly, the equivalent casebook for the main dispensary, maintained by the same midwifery pupil population, used the title 'Mrs' and a single surname for all its apparently married patients (99.5% of the whole).

[12] T. C. Smout *A Century of the Scottish People, 1830-1950* (London: William Collins, 1986), p. 173, quoting M. W. Flinn (ed.) *Scottish Population History from the 17th Century to the 1930s* (Cambridge: Cambridge University Press, 1977), pp. 350-1.

[13] 1870 Outdoor casebook [OCB], case 5105a [140/5105a/70fo]; Registrar-General for Scotland [RGS], *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 1.

> subsequent marriage of its parents ... in the great majority of cases the father ... belonged to the same rank as the mother ....[14]

When their economic circumstances were more favourable, then these couples would marry and legitimise their existing children.[15] If such mothers are genuinely appearing in the Outdoor books, they give some indication of the social level from which Dispensary patients came. Unfortunately, in casebook terms, they can only be looked for if they appear as Indoor patients recorded in the older-style Births Registers, as these were intended to include the addresses of all fathers as well as mothers, and the two can be compared. The evidence is inconclusive. In 1850 seven of the 156 single patients were living with the father of their children, whilst a further 16 possibly did so. In 1870 six of the 137 single Indoor patients shared a home with the baby's father, and four of these were parous. However, the social origins of two of these women were recorded: they were children of the 'industrial' class (V), not of agricultural workers.[16] Four of the partners also belonged to this class, the others being members of the 'commercial' class (III).[17] However, in 1912 Bella B, 28, a laundress with a contracted pelvis, confided to the admitting house surgeon that she 'desired a live child as she's to be married as soon as well again',[18] whilst another patient, Mrs Q, was described as having a 'Scotch marriage'.[19] Despite this example, the recorded decline in apparently single women using the ERMH and, particularly the dispensary, may indicate the decline, in an increasingly urban society, of the rural practice of later, economically-driven marriage, preceded by a long-term relationship and children. Smout notes that in the later nineteenth and early-twentieth centuries, Scottish illegitimacy declined most in urban and industrial counties, where there were fewer constraints on marriage.[20]

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[14] RGS, *Census of Scotland, 1871*, (Edinburgh: Murray and Gibb, for Her Majesty's Stationery Office, 1874), Vol. II, p. lix.

[15] Smout, *A Century of the Scottish People*, pp. 165-73; Andrew Blaikie, 'Scottish Illegitimacy: Social Adjustment or Moral Economy?', *Journal of Inter-Disciplinary History*, XXIX:2 (Autumn, 1998), pp. 221-41. Both describe this as being a feature particularly of the south-west and north-east of Scotland, although it also occurred in the south-east.

[16] Their fathers were respectively a tailor, and a joiner.

[17] Their partners were a labourer, a publican, two shop men, (all Class V), a van man, and a clerk. (RGS, *Census of Scotland 1881*, Table XV, 'Summary of the Occupations of the Inhabitants ... in Classes, Orders, and Sub-orders', pp. 398-405).

[18] 1912 ICB, case 28 (Dr Haultain's quarter) [FWNH] [28/028/hault/1912i]: ERMH Special & Ordinary Casebook [SOCB], pp. 15-16. The surnames of ERMH patients after 1902 have been coded.

[19] 1912 SOCB, p. 40. This probably means marriage by custom and repute.

[20] Smout, *A Century of the Scottish People*, p. 173.

Nonetheless, throughout the nineteenth century, whilst married women always formed the majority of dispensary patients, single women predominated as Indoor patients, reaching a peak in 1870, when 74% were recorded. However, by 1912 the trend was reversed, and their number was slightly exceeded by that for married women. In 1890 an additional feature was that 16% of these (and 10% of all patients) were inmates of five identifiable 'mother and baby' homes in the neighbourhood of the hospital. By 1912, 25.9% of single women were admitted from three such establishments.

Further information is available on the relationships of Indoor patients. The child's father's name was recorded, along with his occupation and address, as separate categories, in both 1850 and 1870, but was removed from the Births Registers when the design was changed in 1877. In 1850 153 out of the 155 single patients whose records are complete gave a name for the baby's father, and one of those who did not, knew his occupation. The other said he was '[u]nknown! – [s]tates she was forced by some unknown person in the country at 11 at night,' to which the sceptical house surgeon added, '[h]ighly unlikely as she is a strong powerful woman'.[21] Whilst this interjection raises questions about his attitude to his patients, it also acts as a reminder that answers given to this question were not necessarily the truth. The residences of ten other putative fathers were not known, although their names and occupations were, whilst three addresses were unrecorded, although the record was otherwise complete. This group included a writer,[22] who might have wished some protection.

In 1870 there was a much greater general tendency on the part of recorders to leave blank spaces in the Register, either because no answer was forthcoming, or because the question was not asked. However, of 137 patients, only seven failed to give a full name for the father. Three were recorded as not knowing his name, one of whom knew his Christian name was Thomas, but for four the entry was left blank. In

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[21] 1850 ICB, case 2234 [144/2234/50si].
[22] Scots: a lawyer.

addition, two women did not know the father's occupation, or whether he was still alive (although one of these gave the father's name). However, for a further 12, no entry for occupation was made: this included five of the 'nameless' group. The women were least likely to know the father's current residence, which suggests that abandonment had led to their admission. Four fathers were dead, and five had gone to America, but a further 15 women answered, with Euphemia Fairley, '[d]on't ken where',[23] whilst Anne McPherson said of her partner, '[t]o Parts Unknown he has eloped'.[24] The whereabouts of another nineteen new fathers were unrecorded.

Direct information about the fathers of illegitimate children born in the ERMH ceases after 1877. However, in both years studied, the great majority of mothers claimed to be able to identify the father of their child, and to support their claim with some personal detail, although there was an overall decline in their number between 1850 and 1870. This does suggest that the majority of single patients were not prostitutes, as was suspected by the Ladies' Committee,[25] but that they were either using the hospital as a place to deliver an 'accident,' or fell into Stark's category of being in a permanent relationship, but too poor to marry.

However, in each year studied, a small number of patients tried to deceive the recorder as to their marital status: their failure is shown, prior to 1877, by a different pen adding 'un' to the original entry.[26] After the change in the Births Registers, any entry in the 'Date of Marriage' column was scored out. In 1912 Juliet G claimed to be the wife of Harry X, a sculptor, but all references to him were deleted, and her occupation of 'clerkess' inserted.[27] This does imply that patients believed that the married state was considered desirable in hospital (either to get better treatment or to avoid moralising), but it may indicate that such patients were in secure relationships in which they considered themselves to be married. It also raises the question of the hospital's attitude: did the addition of 'un' indicate the hospital's moral stance, or

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[23] 1870 ICB, case 1667 [083/1667/70fi].
[24] 1870 ICB, case 1662 [078/1662/70fi].
[25] See, for example, ERMH Directors' Minutes [DMERMH], 8 December 1876.
[26] See, for example, 1850 ICB, case 2018 [053/2018/50fi]; 1850 ICB, case 2138 [048/2138/50si].
[27] 1912 ICB, case 134 JHC [602/134/hc/1912I].

was it solely an administrative action related to potential claims on the patient's parish?

Thus the variation in marital status between Indoor and Outdoor patients, and over time, shows that in one crucial area the Indoor and Outdoor populations of ERMH users, far from being almost indistinguishable, were very different. Outdoors, whilst most were married, the apparently high number of single women in the first two years studied can be explained by either the continuance of rural custom in new immigrants to the city, or poor recording. By 1890 the division between married and single Outdoors patients was typical of national figures. However, by 1912 almost all Outdoor patients were married, reflecting the urban decline in illegitimacy. Indoors, the majority of patients were single in three of the years studied: only in the fourth year were they exceeded by married inmates. Their apparent knowledge of the baby's father implies that their pregnancies were the result of more than a brief relationship. However, the fact the couples did not live together possibly suggests that most were not intending to marry later when this could be afforded, although Smout and Blaikie both imply that to live apart would also have been the rural arrangement. The desire to appear married, and the gradual increase in 'mother and baby' home inmates, both of which are evident in the Births Registers, suggest a developing punitive attitude to illegitimacy in Scots society as a whole. Certainly the middle-class Ladies Committee, who associated the married state with morality rather than economics, felt the presence of single women repelled married patients, and thus retarded the hospital's development from being principally a shelter to a source of rest and medical treatment for the parturient sick.[28]

3.2.2 Age

Over the four years 1850, 1870, 1890 and 1912 there was an increasing differential in age between Indoor and Outdoor patients when seen as a whole.[29] This is

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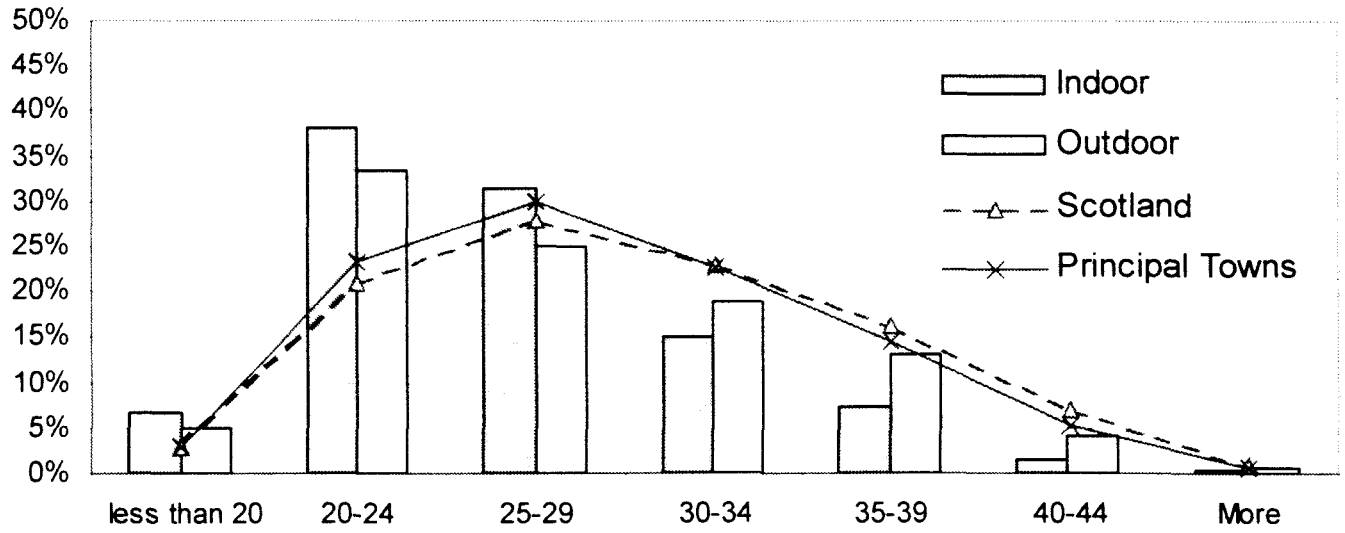
[28] This was the rationale behind the Married Women's Pavilion, campaigned for from at least 1881, and finally opened in 1895. (DMERMH, 3 March 1881, 26 September 1896).

[29] This is based on data recorded in the casebooks. In 1850 Indoor patients' ages were recorded in 96.8% of cases, in 1870 95.8%, in 1890 99.3% and in 1912 98.5%. In the Outdoor casebooks, which appear less well maintained, ages are recorded in 94% of cases in 1850, 87% in 1870, 97% in 1890 and, in 1912, 99% in the main dispensary book and 98% in the Leith Branch book.

especially noticeable when the hospital and dispensary age data are plotted as discrete years against data on maternal age at delivery collected in 1855-6 and published in the 1871 Census of Scotland (Figures 3.3-3.6). [30]

From the 1855 figures it can be seen that in Scotland as a whole, the peak childbearing age, involving 28% of mothers, was in the range 25-30 years. Only 21% were in the 20-25 age group who dominated the ERMH Indoor figures in all four years analysed. The census also categorised Scotland into five Divisions, principal, large and small towns, mainland-rural, and insular districts. Edinburgh was one of the eight principal towns, and in this division too the peak age for births was 25-30, involving 30% of mothers. Thus, it can be seen that the mothers who used the ERMH as Indoor patients were younger than the norm. Comparative youth was also a feature of those who used the Outdoor service in 1850 and 1870, although the trend was less marked. However, in 1890 and 1912 their ages conformed fairly closely to the 1855 figures. This closeness to the norm suggests that by these dates the dispensary was delivering a typical population of parturient women.

Figure 3.3
The Age Range of All Mothers, Derived from 1855 Figures, Contrasted with the Age Range of All ERMH Indoor and Outdoor Patients, 1850



Source: ERMH Indoor and Outdoor Casebooks, 1850; 1871 Census, Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855 ...'.

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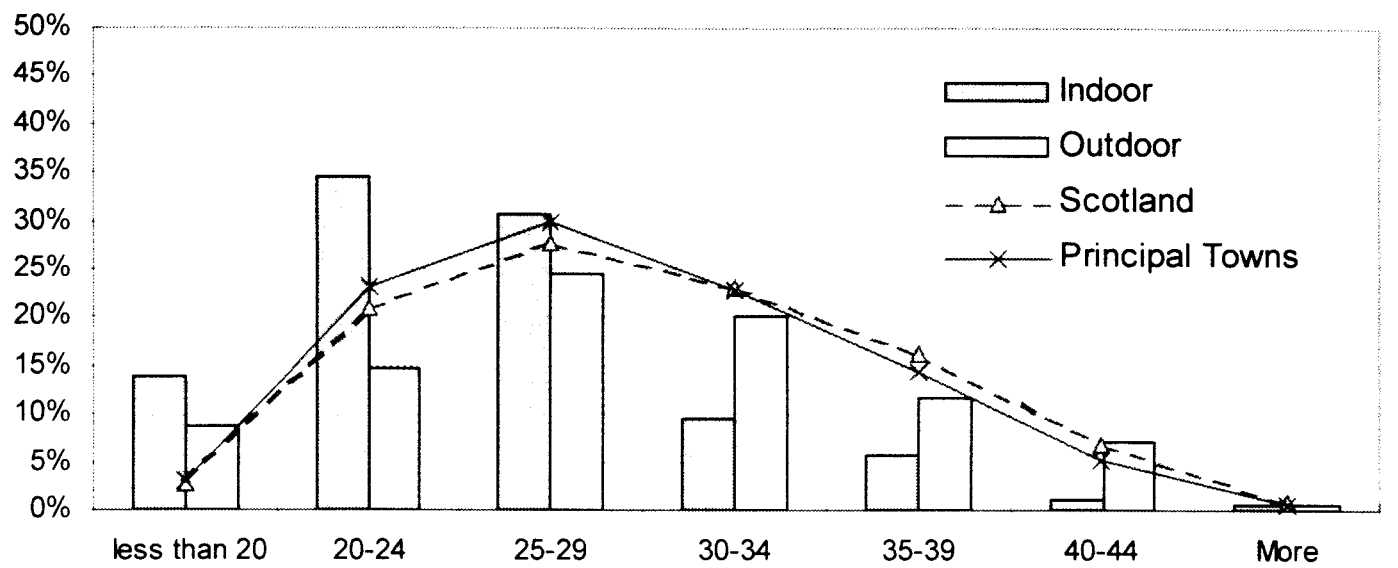
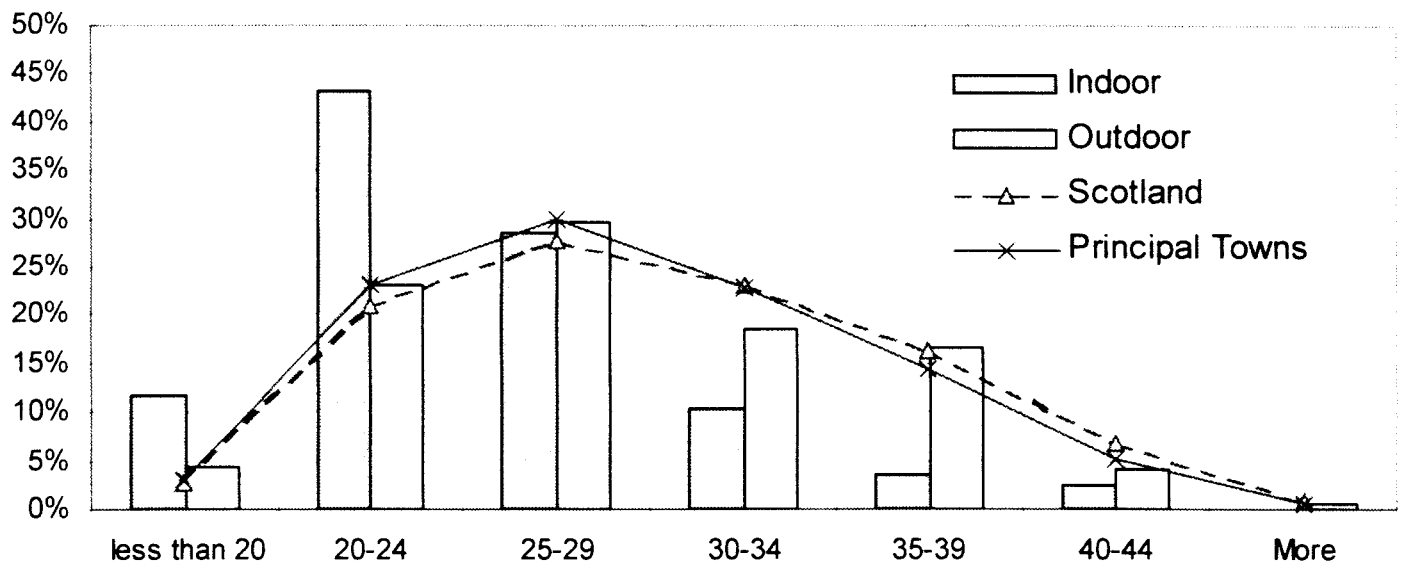
[30] RGS, *Census of Scotland for 1871*, pp. lxiii-lxvii, especially Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855 ... and the percentage at each age ...'. This census included tables based on information provided at the registration of births in 1855, to demonstrate the ages of mothers bearing children in Scotland.

Figure 3.4
The Age Range of All Mothers, Derived from 1855 Figures, Contrasted with the Age Range of All ERMH Indoor and Outdoor Patients, 1870



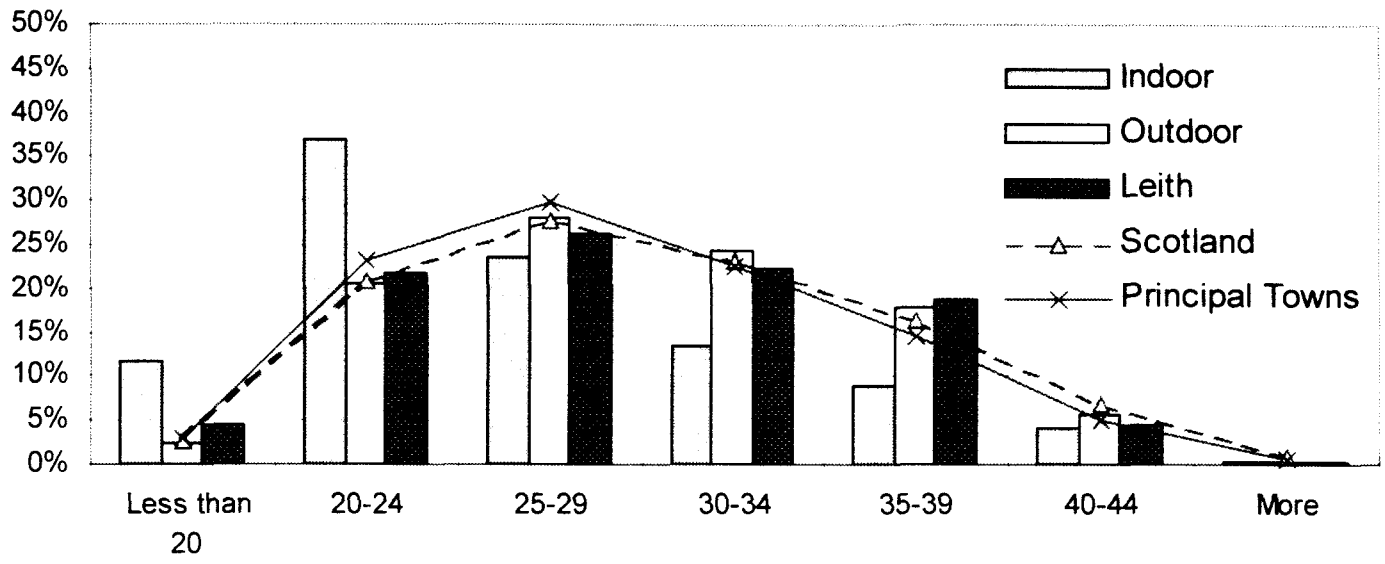
Source: ERMH Indoor and Outdoor Casebooks, 1870; 1871 Census, Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855 …'.

Figure 3.5
The Age Range of All Mothers, Derived from 1855 Figures, Contrasted with the Age Range of All ERMH Indoor and Outdoor Patients, 1890



Source: ERMH Indoor and Outdoor Casebooks, 1890; 1871 Census, Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855 …'.

Figure 3.6
The Age Range of All Mothers, Derived from 1855 Figures, Contrasted with the Age Range of All ERMH Indoor and Outdoor Patients, 1912



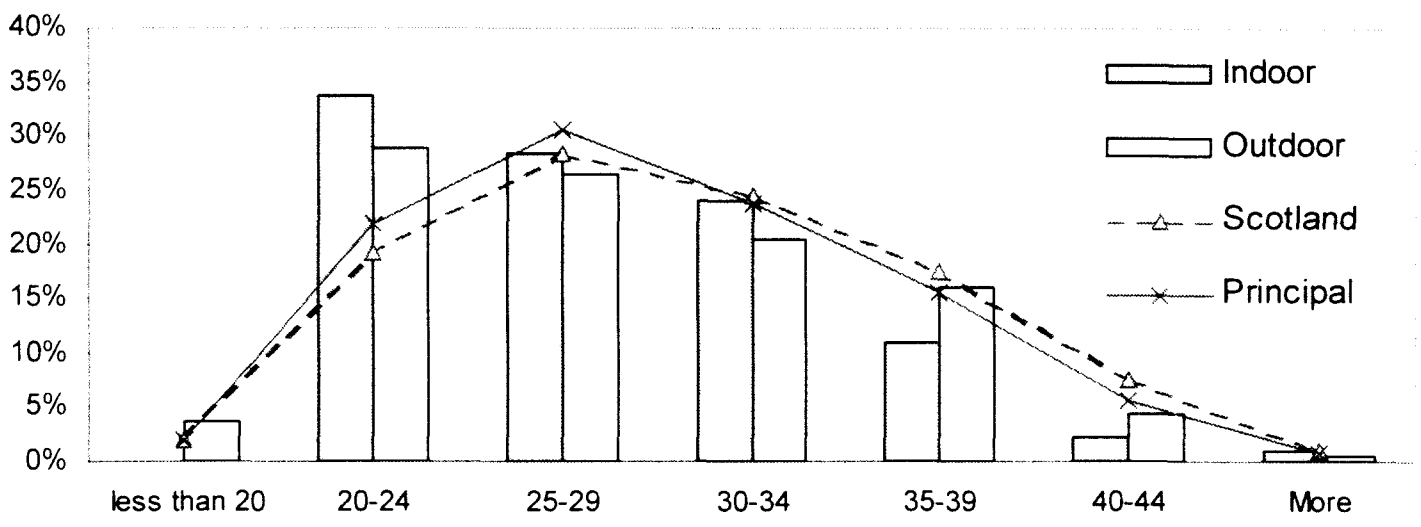
Source: ERMH Indoor and Outdoor Casebooks, Students' External Casebook (Leith Branch), 1912; 1871 Census, Table XIX, 'Number of mothers at each quinquennial age who bore children in 1855...'.

Although the preponderance of single women in the hospital undoubtedly exaggerated the age range pattern of the institution, if the patients' ages are seen in relation to their marital status only slightly more conformity to the census can be seen amongst the in-patient married women. Again using information collected in 1855, the 1871 census distinguished between the ages of married and single women bearing children, and the hospital and dispensary data have been plotted against these (Figures 3.7-3.10).

It can be seen that in the first three years studied the majority of married Indoor patients were younger than the norm, whilst there were very few patients at the chronological end of their fertile life. However, although it is noticeable that in 1850, the year of study closest to when the data was collected, the peak amongst Outdoor married patients occurs in the age range 20-24, in the later years studied there was more conformity to the national pattern. By 1870, although the percentages were smaller, Outdoor married women conformed to the pattern of the national data on age. In 1890 and 1912 the Outdoor data was entirely compatible with that collected for the principal towns of Scotland, implying that by 1890 the Outdoor married parturient population was typical of the child-bearing population as a whole in regard

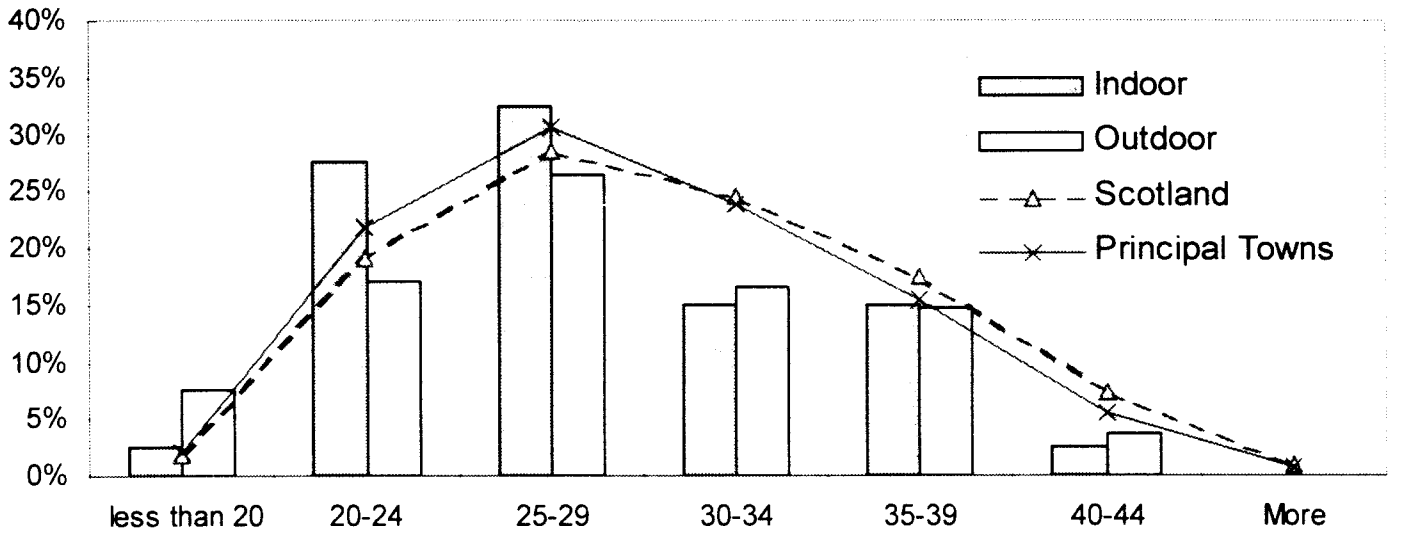
to age. By 1912 (57 years after the data was collected), this was also true of the Indoor married patients. The ages of the majority of mothers who attended both the hospital and dispensaries in that year suggest that the Indoor and Outdoor married populations were consistent with the only data available for the parturient population as a whole. Given that obstetric reasons for admission can affect any age group, the fact that by 1912 the hospital's married patients as a whole were typical of the national parturient population, suggests that those admitted came for treatment rather than for any other reason. However, the earlier discrepancies imply that the nineteenth-century married hospital population was atypical and that, for whatever purpose, younger, married, poor, parturient women were more likely to attend an institution.

Figure 3.7
The Age Range of Married Women, Derived from 1855 Figures, Contrasted with the Age Range of Married ERMH Indoor and Outdoor Patients, 1850



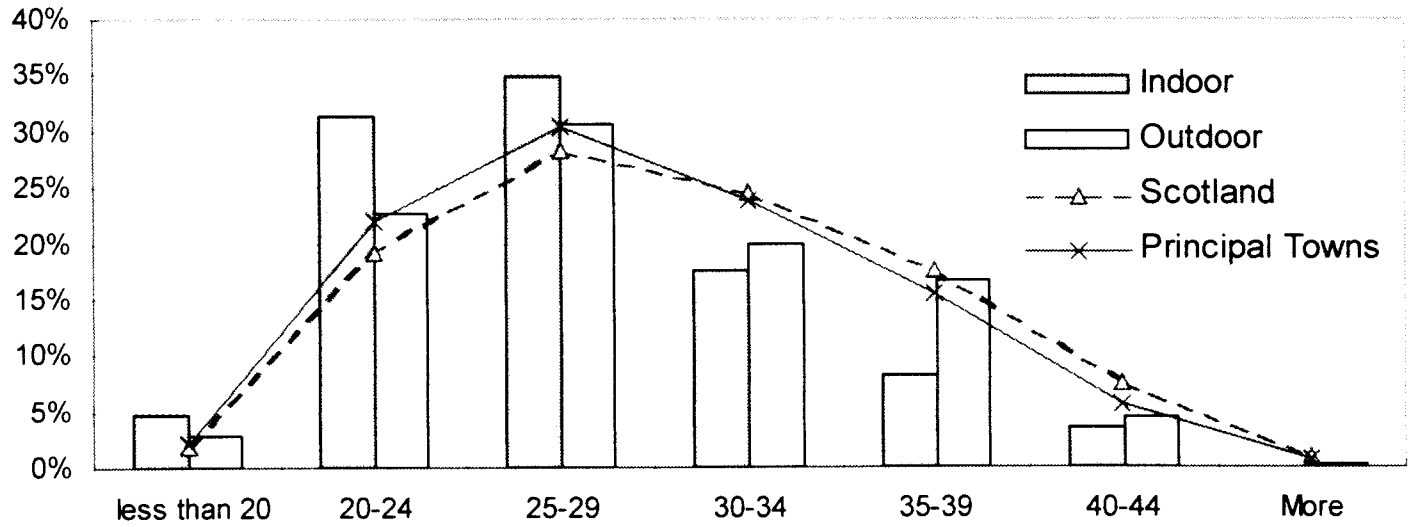
Source: ERMH Indoor and Outdoor Casebooks, 1850; 1871 Census, Table XXII, 'Number of married women at different ages who bore children in Scotland ... in 1855 ...'.

Figure 3.8
The Age Range of Married Women, Derived from 1855 Figures, Contrasted with the Age Range of Married ERMH Indoor and Outdoor Patients, 1870



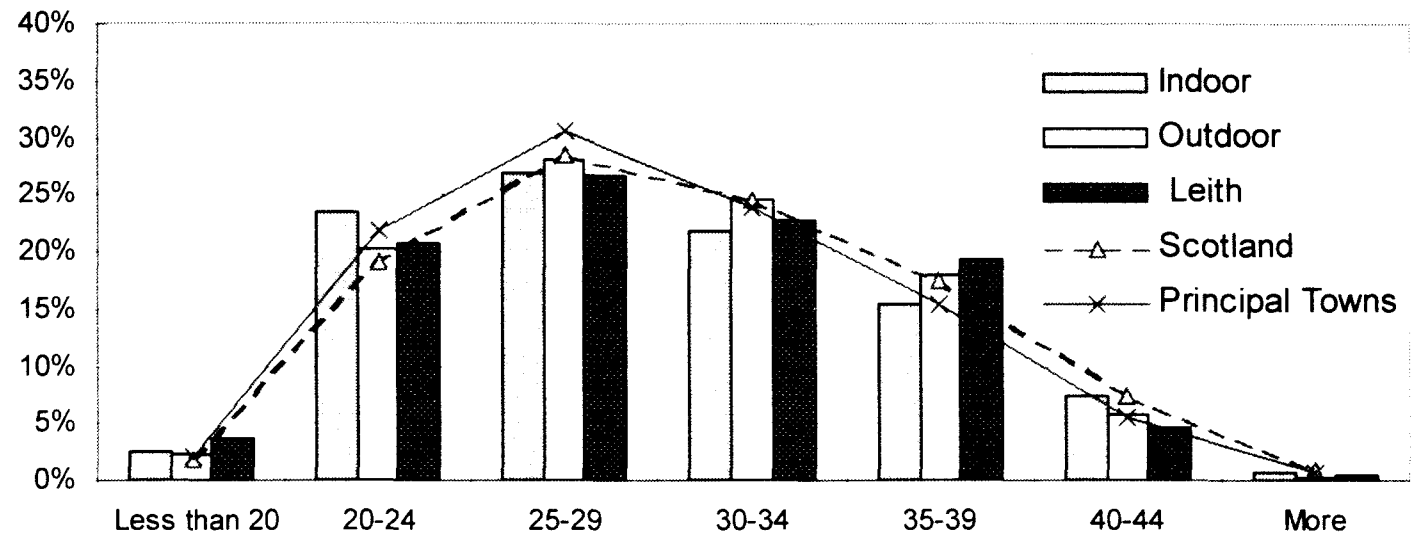
Source: ERMH Indoor and Outdoor Casebooks, 1870; 1871 Census, Table XXII, 'Number of married women at different ages who bore children in Scotland ... in 1855 ...'.

Figure 3.9
The Age Range of Married Women, Derived from 1855 Figures, Contrasted with the Age Range of Married ERMH Indoor and Outdoor Patients, 1890



Source: ERMH Indoor and Outdoor Casebooks, 1890; 1871 Census, Table XXII, 'Number of married women at different ages who bore children in Scotland ... in 1855 ...'.

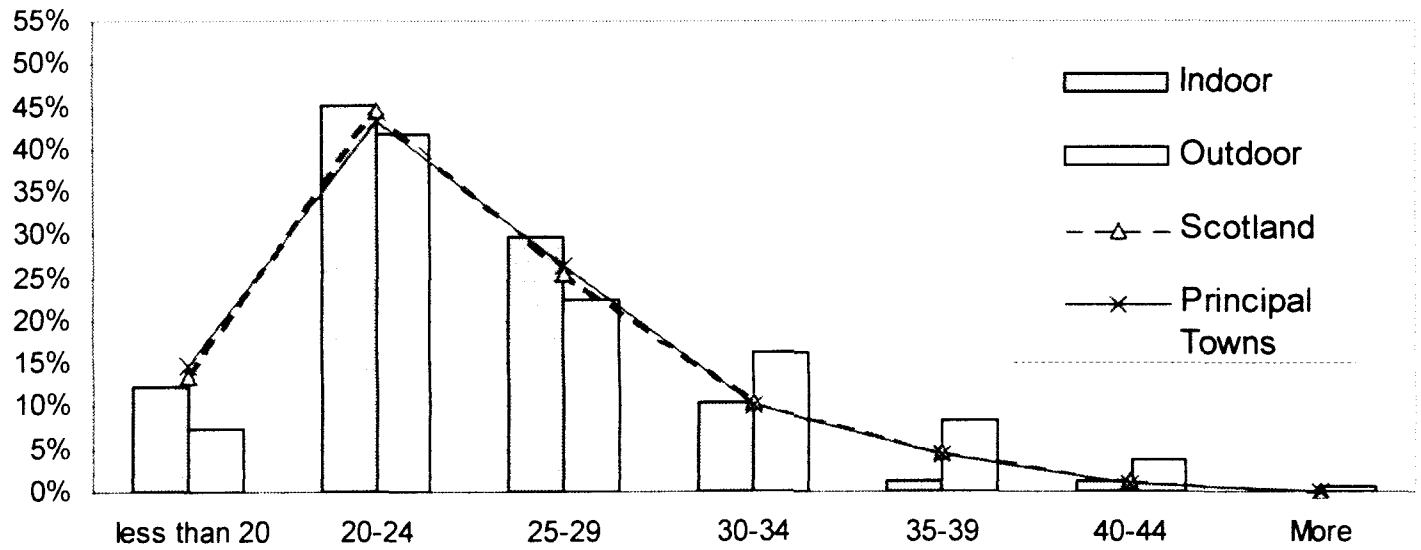
Figure 3.10
The Age Range of Married Women, Derived from 1855 Figures, Contrasted with the Age Range of Married ERMH Indoor and Outdoor Patients, 1912



Source: ERMH Indoor and Outdoor Casebooks, Students' External Casebook (Leith Branch), 1912; 1871 Census, Table XXII, 'Number of married women at different ages who bore children in Scotland ... in 1855 ...'.

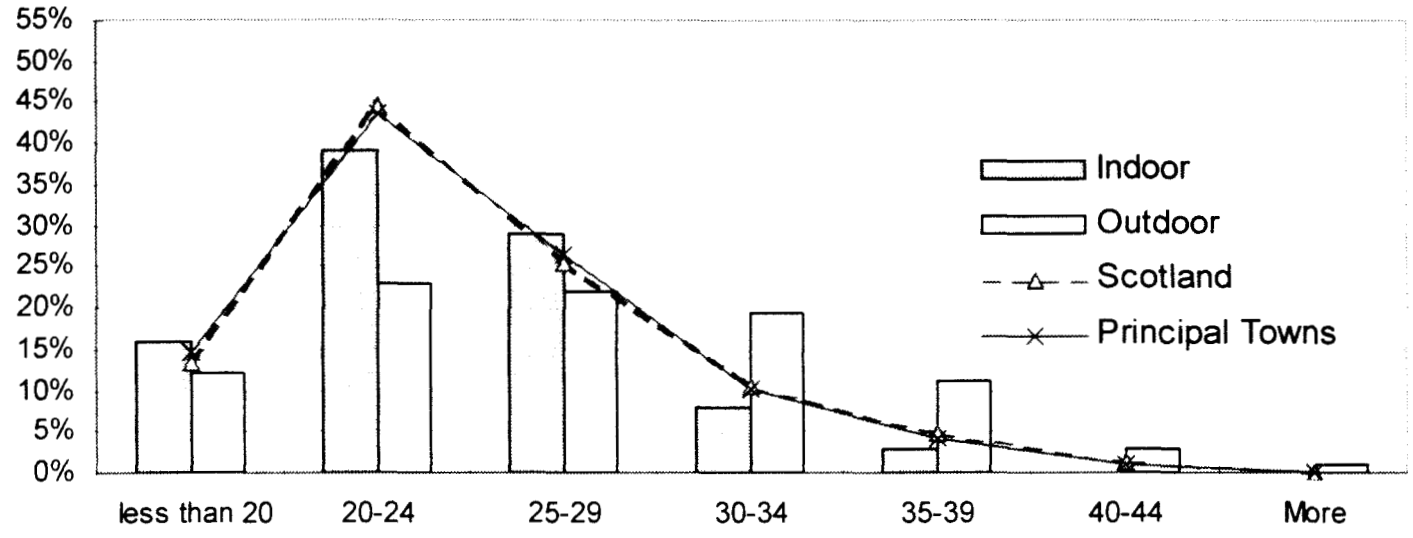
The data for single patients have also been plotted against that from the 1871 Census (Figures 3.11-3.14).

Figure 3.11
The Age Range of Single Women, Derived from 1855 Figures, Contrasted with the Age Range of Single ERMH Indoor and Outdoor Patients, 1850



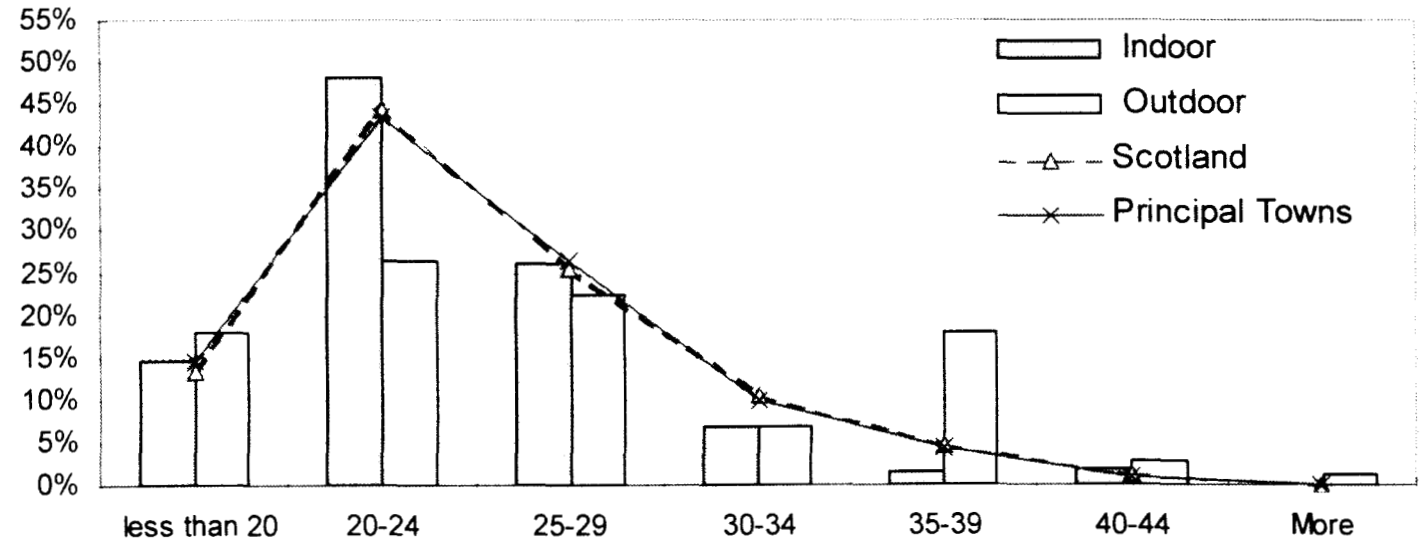
Source: ERMH Indoor and Outdoor Casebooks, 1850; 1871 Census, Table XXIII, 'Number of unmarried women at different ages who bore children in Scotland ... in 1855 ...'.

Figure 3.12
The Age Range of Single Women, Derived from 1855 Figures, Contrasted with the Age Range of Single ERMH Indoor and Outdoor Patients, 1870



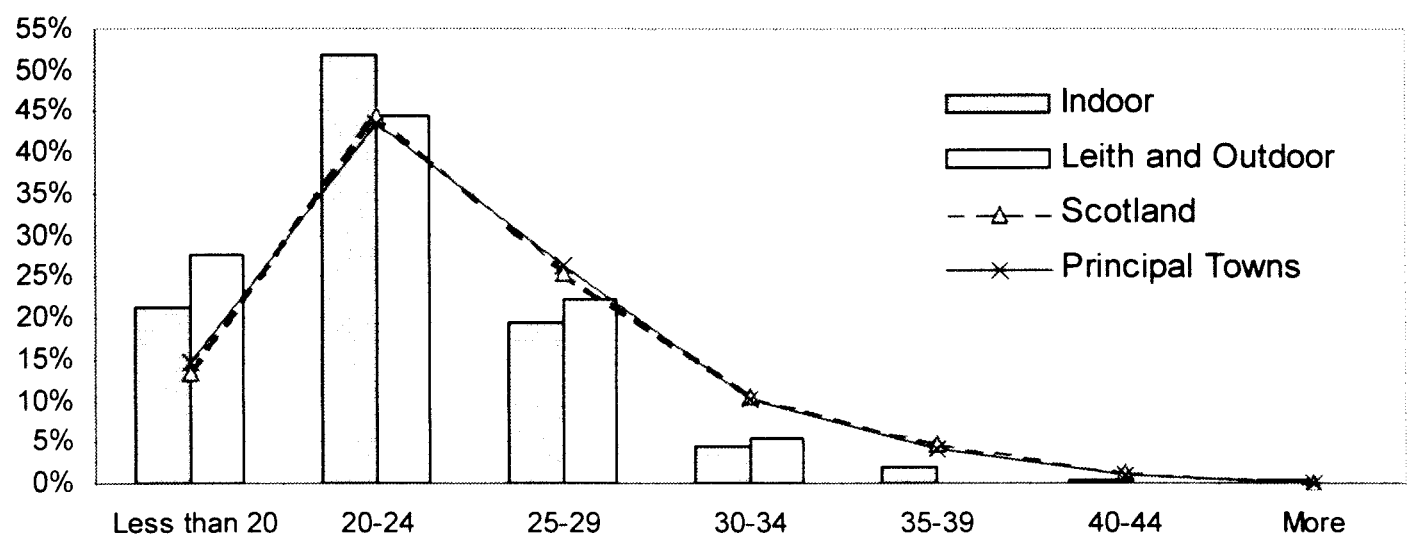
Source: ERMH Indoor and Outdoor Casebooks, 1870; 1871 Census, Table XXIII, 'Number of unmarried women at different ages who bore children in Scotland ... in 1855 ...'.

Figure 3.13
The Age Range of Single Women, Derived from 1855 Figures, Contrasted with the Age Range of Single ERMH Indoor and Outdoor Patients, 1890



Source: ERMH Indoor and Outdoor Casebooks, 1890; 1871 Census, Table XXIII, 'Number of unmarried women at different ages who bore children in Scotland ... in 1855 ...'.

Figure 3.14
The Age Range of Single Women, Derived from 1855 Figures, Contrasted with the Age Range of Single ERMH Indoor and Outdoor Patients, 1912



Source: ERMH Indoor and Outdoor Casebooks, Students' External Casebook (Leith Branch), 1912; 1871 Census, Table XXIII, 'Number of unmarried women at different ages who bore children in Scotland ... in 1855 ...'.

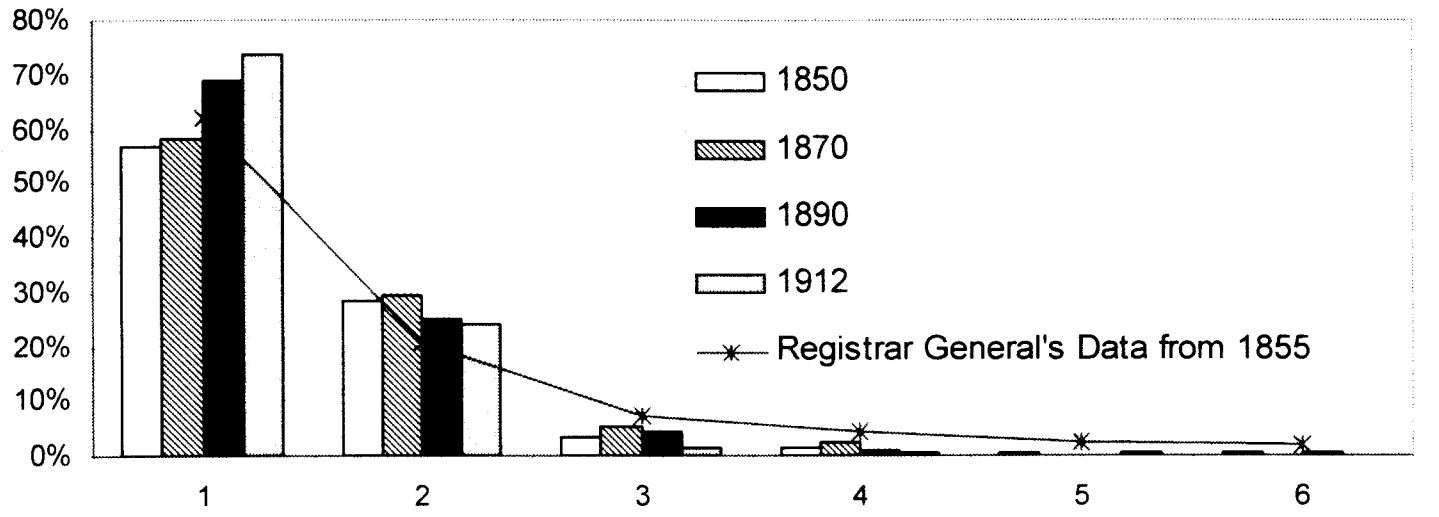
It can be seen that in 1850 Indoor single patients conform very closely to the figures both for the Principal Towns and nationally. In 1870 the hospital figures failed to attain the percentages of the national figures, whereas in 1890 and 1912 they exceeded them. This suggests that in these two years the hospital was taking an excessive proportion of young single women, which is entirely compatible with the increasing number of admissions from 'mother and baby' homes. Lack of conformity to national data amongst Outdoor single patients should, in the absence of evidence to the contrary, be ascribed to failure to identify or understand them correctly, although some could have been representatives of a group described in the 1861 census as being married in all but name. However, the Indoor single population conformed closely in pattern to the national data.

3.2.3 Parity

The hospital regularly recorded the parity of both Indoor and Outdoor patients, and again the hospital figures can be compared with those collected for all Scottish

mothers in 1855.[31] Figure 3.15 shows the parity of single Indoor patients, 1850-1912, compared with the national figures.[32]

Figure 3.15
The Parity of Unmarried Women in Scotland, in Contrast to that of Single Indoor Patients at the ERMH, 1850-1912



Source: ERMH Indoor Casebooks, 1850, 1870, 1890, 1912; 1871 Census, Table XXV, 'Unmarried women who had children in Scotland in 1855 ...'.

In both 1850 and 1870 the hospital figures were slightly below the national average for a first child, but above it for a second. In 1890 and 1912 the hospital figures were above the norm for both first and second children, but then tailed away, as did those of the earlier years. The ERMH's close relationship with three 'mother and baby' homes, which claimed to admit primigravidae only, accounts for the rise in first children, but not that in second.[33]

Figure 3.16 shows similar data on unmarried mothers Outdoors.[34]

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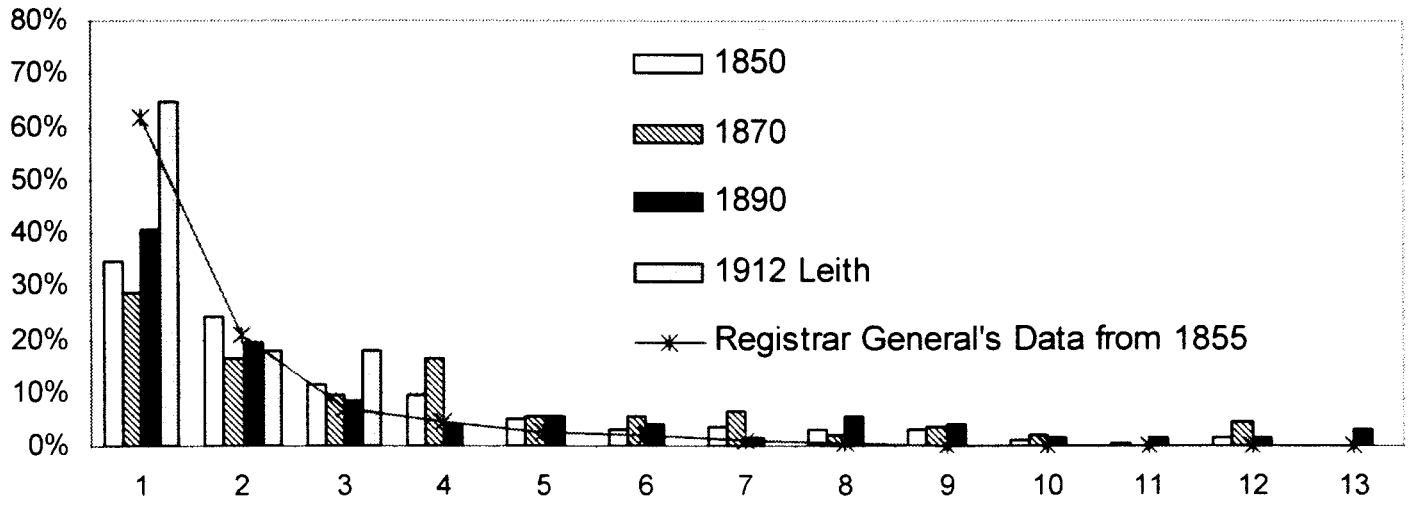
[31] RGS, *Census of Scotland for 1871,* p. lxix, Tables XXIV, XXV. It should be noted that whilst this information was collected for 99.7% of married women who bore a child in 1855, it was only collected for 24.1% of similar single women.
[32] This data was collected in 91% of cases in 1850, 94.9% in 1870, and thereafter in 100% of cases.
[33] See the ERMH Annual Report of 1907 for a description of the admission requirements for such a home. (ERMH Annual Report [ARERMH] for 1907).
[34] This data was collected in 98.5% of cases in 1850, 95.4% in 1870, and thereafter in 100% of cases.

Figure 3.16
The Parity of Unmarried Women in Scotland, in Contrast to that of Single Outdoor Patients at the ERMH, 1850-1912



Source: ERMH Outdoor Casebooks, 1850, 1870, 1890, Students' External Casebook (Leith Branch) 1912; 1871 Census, Table XXV, 'Unmarried women who had children in Scotland in 1855 ...'.

Here the picture is more complex. The data for 1912, which represents the 17 Leith patients not given the title 'Mrs',[35] adheres closely to the national figure for first and second children, but exceeds it for third children. In the three earlier years studied, the hospital data is considerably below the national average for first children, approaching it for second, and exceeding it by the third and subsequent births. A number of explanations are possible. Firstly, as has been noted before, the marital state of the women involved may have been misinterpreted, or rather their long-term relationship with their children's father may not have been recognised, which would account for the two single women each having their tenth child in 1870.[36] Secondly, the small percentage of single mothers on whom the national data was based may have been atypical. Further, the delivery of a first illegitimate child may have been carried out by another agency, such as the girl's mother, or through a 'mother and baby' home, which would not admit her a second time. If this were the case, her first delivery might well have contributed to the in-patient figures.

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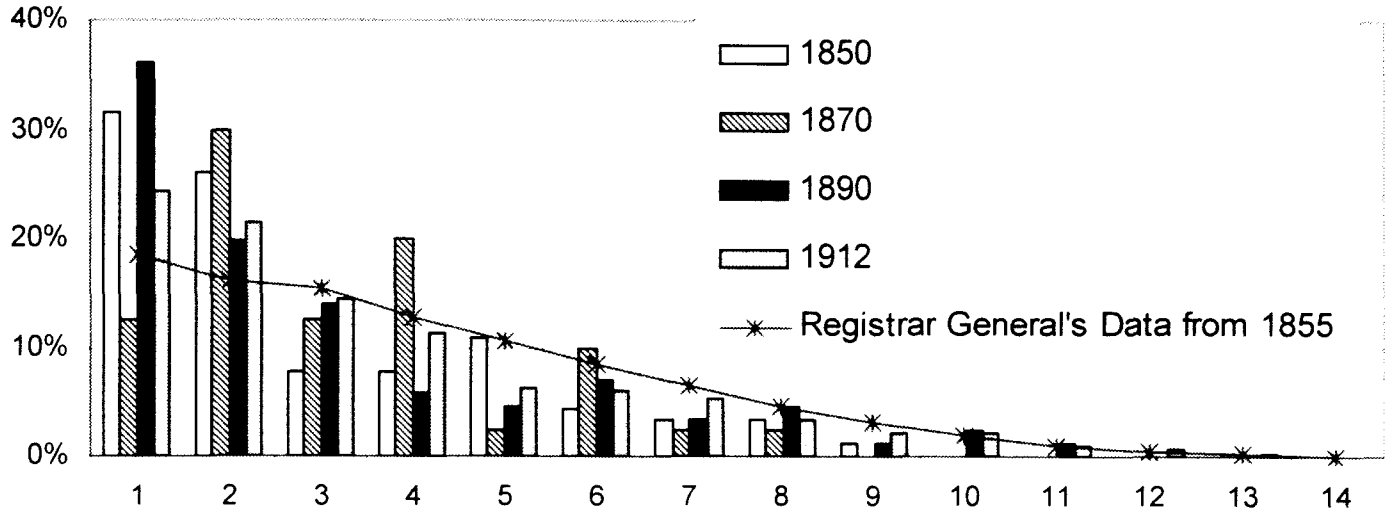
[35] In the main dispensary only four patients in the Students' External Casebook meet this criteria, of whom two are given the title 'Mrs' in the Outdoor casebook. All four have been excluded from these figures.
[36] 1870 OCB, cases 5038 and 546 [013/5038/70fo], [020/546/70fo].

The picture for married women, both Indoors and Outdoors, is equally complex. Figure 3.17 shows the data from the Indoor casebooks.

Figure 3.17
The Parity of Married Women in Scotland, in Contrast to that of Married Indoor Patients at the ERMH, 1850-1912



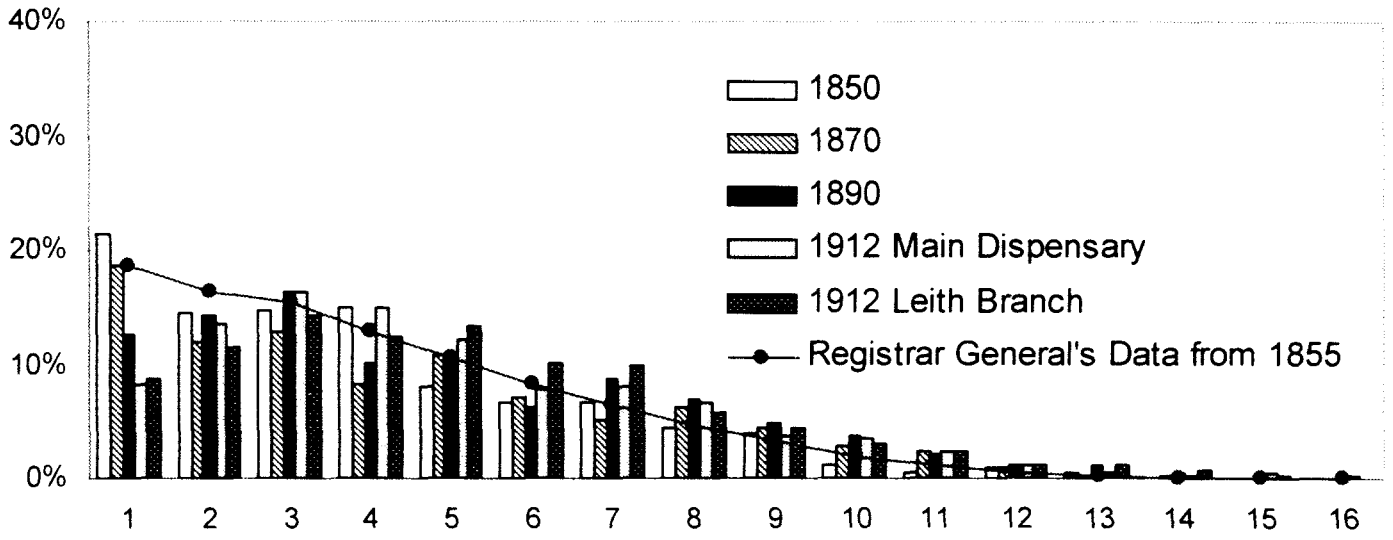
Source: ERMH Indoor Casebooks, 1850, 1870, 1890, 1912; 1871 Census, Table XXIV, '... Married women and number of children which they had on the birth of their last child in Scotland in 1855'.

In 1850, the parity of married Indoor patients was similar to that of single Indoor patients. Most of the 93 patients were having their first or second child, and thereafter, despite a small recovery at the fifth child, their parity declined steeply. In 1870, the pattern created by only 40 patients was very different. The largest number were having their second child, although in percentage terms they also exceeded the national figure for fourth and sixth children. This small percentage of first births to married women is not seen Indoors in any other year. In both 1890 and 1912 most married women in-patients were delivering their first child. In 1890, the percentage involved in other births was small, and with one exception, under the national figure. This similarity between the Indoor married and single figures may have resulted from a number of hasty marriages. In 1890, using data on year of marriage incorporated in the new Births Register, it can be seen that 10 of the 86 married patients had married in that year, half of whom were pregnant on marriage. In 1912, 11 of the 29 patients married in that year were pregnant before they married. The significance of hasty marriages associated with the hospital is unclear. They may be the last vestiges of rural bridal pregnancy or admission may again be the result of

poverty in newly-married couples. The excess in primigravidae can also be partly explained by the rise in admissions for illness, principally eclampsia, which most frequently affects women having their first child. Seven women were admitted for this cause alone in 1912, compared with two in 1890. However, whilst the figures for 1912 exceeded the norm for first and second births, thereafter they stayed close to it, again suggesting that by 1912 sufficient married women were admitted for medical reasons for them to resemble the national pattern for childbearing women, at least as recorded 57 years before.

The figures for the parity of married women appearing in the Outdoor casebook are also very variable, as can be seen in Figure 3.18.

Figure 3.18
The Parity of Married Women in Scotland, in Contrast to that of Married Outdoor Patients at the ERMH, 1850-1912



Source: ERMH Outdoor Casebooks, 1850, 1870, 1890, 1912, Students' External Casebook (Leith Branch) 1912; 1871 Census, Table XXIV, '... Married women and number of children which they had on the birth of their last child in Scotland in 1855'.

In both 1850 and 1870, although the figures fluctuated, rather than following a smooth curve, most Outdoor deliveries to married women were of their first child, and thereafter there was an overall gradual decline in the percentage of mothers involved as parity increased. In both 1890 and 1912, in both the main dispensary and the Leith Branch (1912 only), the percentage of mothers having their first child was low, and rose gradually to a peak with their third child. Percentages then declined, but continued above the norm.

A number of theories suggest themselves. Care in a first labour may again have been given by another agency, either the woman's mother (although by 1912 the number of notified births attended by non-professionals was very small),[37] or a privately-retained professional. If this latter were the case, then the increasing use of the dispensary as family size increased suggests possibly a desire to access quality care, but more probably a decline in the available money to spend on the birth. It can also be speculated that again these women had previously been delivered, before marriage, under the care of a 'mother and baby' home, by another dispensary, or in the hospital. Thus, with regard to parity, whilst single Indoors patients were typical of the recorded population, and by 1912 married Indoor patients were also approaching the norm, Outdoors married patients continued to be atypical. In this respect, and in contrast to age and their marital status, they did not constitute a typical parturient population. The atypical parity of ERMH patients may well have had an influence on the approach to childbirth of its staff. Those who worked principally Indoors, particularly the early twentieth-century house surgeons, would see an excessive number of first deliveries, which are considered most likely to have problems. However, the nurses of the same period delivered parous and, obstetrically at least, problem-free women in their own homes.

Smout writes, in general terms, of a slow decline in the legitimate birth-rate, and thus in family size, in later nineteenth-century Scotland.[38] This is also apparent in the ERMH data. Whilst a small number of married Indoor patients in 1850 and 1870 did exceed the national percentage for grand multiparity,[39] the only Outdoor married patients to do so were those in Leith in 1912 (Figure 3.19).[40] Unfortunately, the data currently available on individual Leith patients is restricted to that found in the

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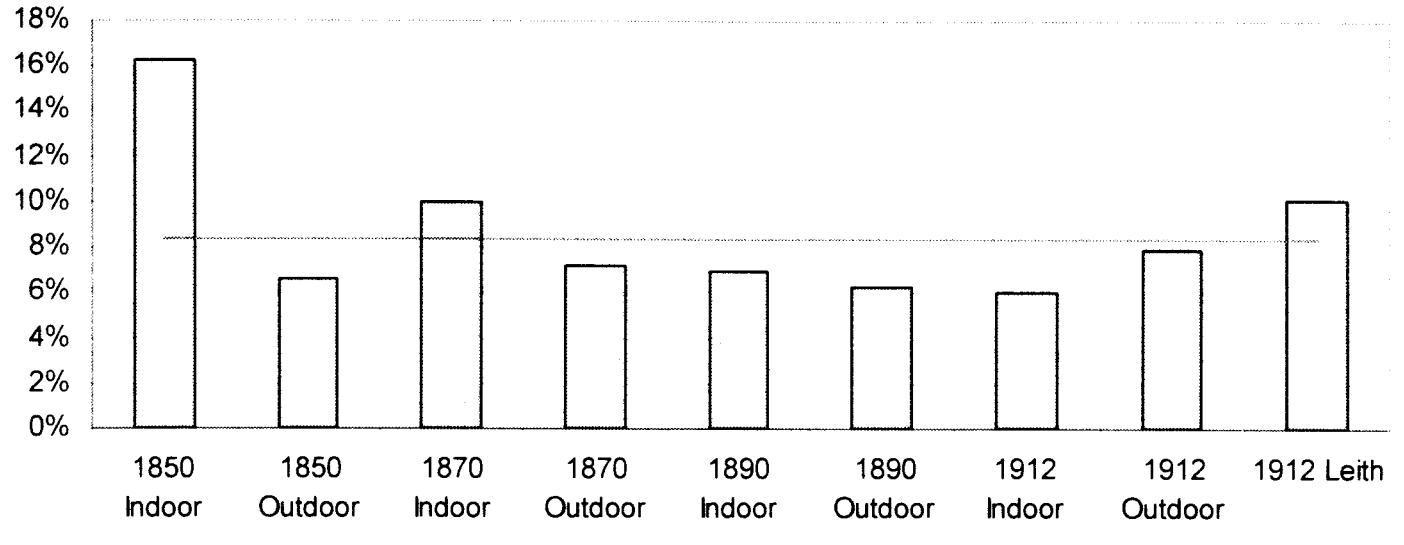
[37] Notification of Birth by both the attendant and parent was introduced in Edinburgh in 1907-8. In 1911, seven births were described as either 'attended by neighbours or were unattended'. (A. Maxwell Williamson *Annual Report of the Public Health Department of the City of Edinburgh for the Year 1911* (Edinburgh: H. & J. Pillans & Wilson, 1912)).

[38] Smout, *A Century of the Scottish People*, p. 174.

[39] A sixth or later birth (Ian Donald *Practical Obstetric Problems,* (London: Lloyd-Luke (Medical Books) Ltd., 1979), p.136). 8.3% of 1855 'married' births were in this category.

casebooks, so the existence of such large families cannot be linked to any particular field of employment or economic circumstance.[41]

Figure 3.19
The Grand Multiparity of Married Women in Scotland, in Contrast to Indoor and Outdoor Patients of the ERMH, 1850-1912



Source: ERMH Outdoor Casebooks, 1850, 1870, 1890, 1912, Students' External Casebook (Leith Branch) 1912; 1871 Census, Table XXIV, '... Married women and number of children which they had on the birth of their last child in Scotland in 1855'.

The line denotes the percentage of grand multiparae recorded in the above Census Table XXIV.

3.2.4 Occupations/Social Class

As part of the details recorded in the earlier Birth Registers, the occupations of the patient's father and partner were recorded. After 1877, this was changed to record the husband's occupation if the patient were married, or her own occupation if she were not. This information can be taken in conjunction with the 'Instructions to Clerks ... classifying the Occupations ... of the People... 1881' and Table XV, 'Occupations of the People of Scotland, 1881' to sort the patients according to their background and the employment of their partners.[42]

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[40] The equivalent percentage for single mothers was 1.8%. This was exceeded Outdoors in 1850, 1870 and 1890, giving further support to Stark's theory of economically-driven marriage following the establishment of a large family.

[41] This is discussed in Simon Szreter *Fertility, Class and Gender in Britain, 1860-1940* (Cambridge: Cambridge University Press, 1996). The fathers of the seven large families at the ERMH in 1850, and the three in 1870, were labourers or small craftsmen.

[42] General Register Office [GRO] *Census of England and Wales, 1881: Instructions to the Clerks Employed in Classifying the Occupations and Ages of the People;* RGS, *Census of Scotland 1881,*

In both 1850 and 1870 slightly over half of all patients for whom the information was recorded,[43] were the daughters of men of the industrial class (V). In each year, approximately 10% were the daughters of the agricultural class (IV), whilst similar proportions were daughters of soldiers (I) or domestic servants (II). The daughters of the commercial class (III), which included seamen and railway workers as well as small shopkeepers, were more heavily represented in 1850 than 1870. Whilst examples such as Jane Grierson, 18, and the daughter of a doctor, who had an illegitimate daughter in May 1850,[44] or Mrs Henry Thomas, daughter of a land surveyor, who delivered her second child in September 1870,[45] stand out, the majority of patients were the daughters of working men, labourers, masons, tailors, and the like. Taken in conjunction with the fact that more than half of the fathers of all patients were dead, this suggests that among other reasons, lack of family resources drove women to become Indoor patients. Similar information is not available for Outdoor patients.

Division of the 1850 patients by their marital status produced no real difference in the proportions of the various employment classifications of their fathers. By 1870 it did: whilst the largest percentage of fathers of both married and single patients were from Class V, for single patients the next largest class of fathers were those engaged in agriculture (10%), whereas for married patients they were more likely to be from the commercial class (8%). This implies that a significant number of single Indoor patients were either sent from the countryside outwith Edinburgh to deliver their illegitimate children in comparative secrecy, or were not returning home to the country, thereby concealing their pregnancy from their rural family.[46]

Table XV, 'Occupations of the People of Scotland, 1881', pp. 398-405. This sorting has also been supplemented by the use of Chambers Scots Dictionary to cross-reference known and apparent Scotticisms, for example, 'writer' and 'flesher'. No difference has been noted between the job classifications of the two censuses. It should be remembered that it was the employment that was classified, not the employee.

[43] In 1850, this information was recorded for 90% of patients; in 1870 it was recorded for 52%.

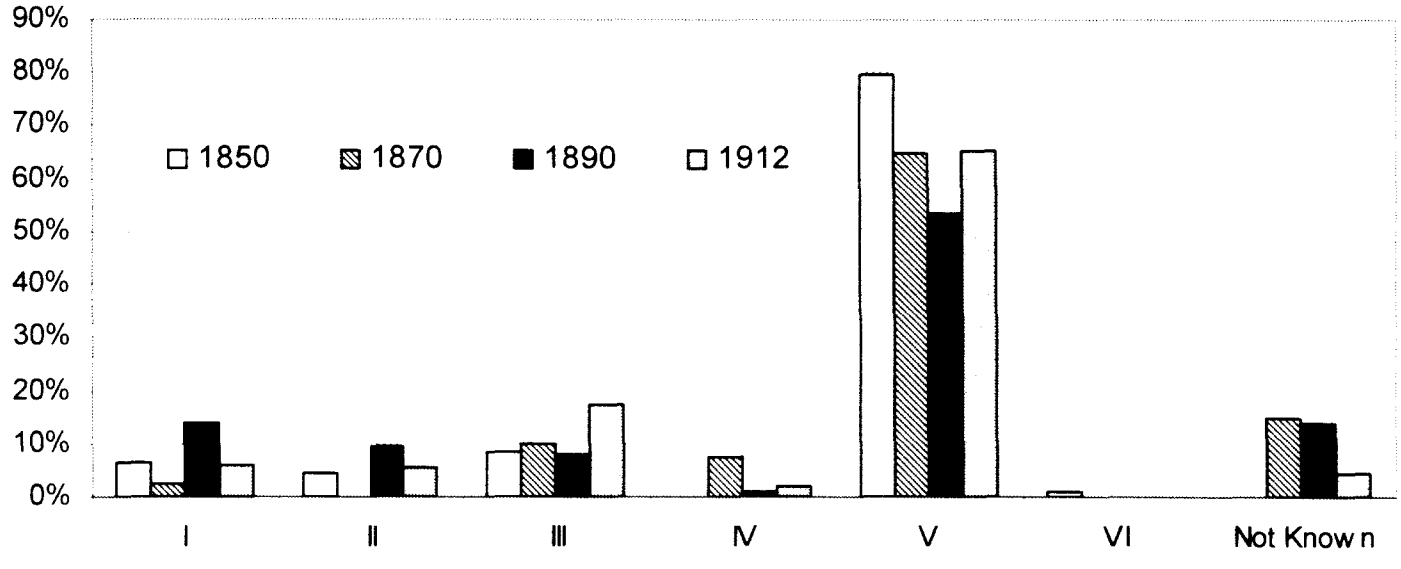
[44] 1850 ICB, case 2050 [085/2050/50fi]. Dr Grierson had died sometime prior to 1850.

[45] 1870 ICB, case 1739 [042/1739/70si].

[46] In 1870 the relevant percentages are, for married patients, Class V, 30%, Class III, 8%, Class IV, 5%; for single patients they are, Class V 35%, Class IV 10%, Class III, 4%. It should be noted that this information was only collected from 46% of married women, and from 56% of single patients.

After 1877 the occupation of the patient's father was no longer recorded, so it is impossible to discuss their likely social class based upon this evidence. However, the hospital continued to record the husband's occupation for married women, and her own if she were single. From Figure 3.20 it can be seen that the majority of husbands were from the industrial class (V), unsurprising in a developing city.

Figure 3.20
The Occupations of the Husbands of Married Indoor Patients at the ERMH, According to General Census Classifications, 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912; 1881 Census, Table XV, 'Occupations of the People of Scotland, 1881'

The number of husbands in agricultural work (IV) declined after 1850, whilst the number engaged in trade and, particularly, transport (III), increased by 1912. It is tempting to ascribe the decline in the number of soldiers' wives (I) as in-patients after 1890, to the attempt by the Soldiers and Sailors Families Association to negotiate cut-price midwifery training at the ERMH for soldiers' wives, and their subsequent presence in the Register of Nurses (at full price). Soldiers' domestic arrangements, and those of men in domestic service (II), may have made a home confinement more awkward. In 1890 Mrs Sutherland, of Caledonian Crescent, wife of a butler, gave birth to her fourth child in the ERMH,[47] whilst ten of the 12 representatives of Class I were soldiers.

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[47] 1890 ICB, case 66 (Dr Underhill's quarter) [CEU] [017/66u/90si].

The husbands of the Outdoor patients traced were similarly employed. In 1850, two were mason's labourers, and one a journeyman tailor. In 1870, small craftsmen predominated, although three were in the building trade and one was a soldier. In 1890 there were more apparent employees, including an insurance agent, two metalworkers, and a butcher in a slaughterhouse. In one instance, indicating severe poverty, both parents worked: he as a coal porter, and she as a paper sorter.[48] The employment of the husbands of both Indoor and Outdoor patients was similar, and shows again the underlying poverty of all ERMH users.

Information on the employment of single patients has been examined for two years, 1890 and 1912, and compared with census data on adult female employment in Edinburgh.[49] In 1890 over 70% were domestic servants, also, at 21%, the largest category of employment in Edinburgh in the 1881 census. 15% were classed as 'industrial', being principally employed as dressmakers and mill workers. By 1912 there had been a decline in the percentage of servants, to 55%, and an increase in those in industry, to 28%. There was also much greater variation in this employment. However, in either year, only 10% were 'at home' or 'of no occupation', the largest overall census category of female occupation in Edinburgh (57%), indicating again that ERMH patients came from the poorest in society. Among the Outdoor patients, one single woman was found in 1870, who worked as a fruit and vegetable hawker. Two were found in 1890, one of whom supported her two children by working as a charwoman and taking lodgers.[50] The other worked as a bookfolder, and lived with her widowed mother, five younger siblings, and two lodgers.[51]

The theme of prostitution amongst ERMH patients was recurrent, with intermittent fears that an establishment such as a maternity hospital encouraged vice by accepting single women as patients. During the 1870s and 80s the ERMH Ladies Committee thought prostitution common amongst Indoor patients, but the doctors disagreed.[52]

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[48] RGS, *1891 Census of the City of Edinburgh,* Registration District 685[1], Enumeration Book 77.
[49] RGS, *Census of Scotland for 1881,* Summary Table XV, 'Adult Female Employment in Edinburgh', p. 672.
[50] RGS, *1891 Census of the City of Edinburgh,* Registration District 685[1], Enumeration Book 65.
[51] RGS, *1891 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 47.
[52] DMERMH, 8 December 1876, 3 March 1881.

However, in 1870, Dr William Wood, the House Surgeon, observed in his quarter that one patient 'is a prostitute',[53] whilst another was 'from the Reformatory',[54] and a third had been leading 'a very irregular life'.[55] Recent writers on nineteenth-century prostitution have associated it with the poverty wages paid in many areas of female employment, and, to a lesser extent, with the vulnerability of many female workers, especially those who lived in provided accommodation.[56] The majority of ERMH single patients did work in such low-paid, tied jobs. In addition, Smout notes that downturns in the trade cycle were likely to move many women normally engaged in casual industrial work, such as milliners and seamstresses, to the streets temporarily.[57] However, in both 1890 and 1912, only a minority of single patients, albeit an increasing one, was employed in Class V. How many patients were engaged in prostitution is impossible to assess, although it should be noted that the vast majority were able to name the baby's father (one hopes with accuracy).

Whilst the appearance of venereal disease is by no means an definite indicator of prostitution, it was seldom noted among the in-patients. In 1870 it was recorded in two Indoor cases, whilst one such patient in 1850 had 'got chancres'.[58] In 1890 two women were described as syphilitic. One, married, delivered twice in the same year.[59] In 1912 one single girl was described as suffering from 'Gonorrhoeal Rheumatism'[60] whilst another, a domestic servant, had 'Specific' written in the 'Comments' box.[61] It is not clear what this means, but it was also applied to a married woman who delivered a putrid late abortion, her sixth miscarriage.[62] The combination of these two women, particularly the history of the latter, hints at

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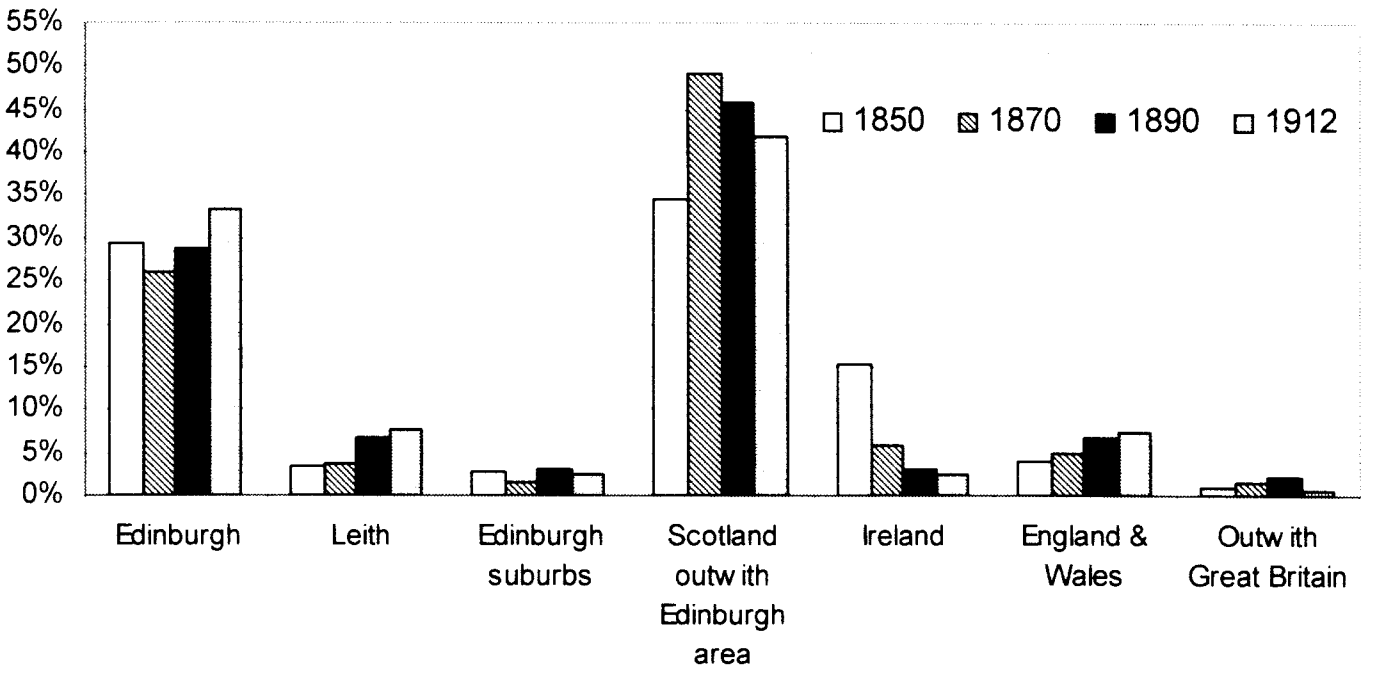
[53] 1870 SOCB, p. 18.
[54] 1870 SOCB, p. 73.
[55] 1870 SOCB, p. 80.
[56] Domestic servants were identified by reformers as making up the majority of the prostitute population, followed by dressmakers, seamstresses, milliners and bonnet makers. (Pamela Horn *The Rise and Fall of the Victorian Servant* (London: Gill and Macmillan Ltd., 1974; Stroud: Sutton Publishing Ltd., 1995), pp. 152-5; Paula Bartley *Prostitution: Prevention and Reform in England, 1860-1914* (London: Routledge, 2000), pp. 3-7).
[57] Smout, *Century of the Scottish People*, pp. 164-5.
[58] 1850 ICB, case 2041 [076/2041/50fi].
[59] 1890 ICB, case 25 (Dr Berry Hart's quarter) [DBH] [051/25bh/90fi]; 1890 ICB, case 18 (Prof. Simpson's second quarter) [ARS2] [107/18ss/90si].
[60] 1912 ICB, case 034 (Dr Ballantyne's quarter) [JWB] [350/034/bal/1912i].
[61] 1912 ICB, case 059 JHC [527/059/hc/1912i].
[62] 1912 ICB, case 146 (Dr Barbour's quarter) [AHFB] [290/146/barb/1912i].

'Specific' being a euphemism for syphilis. However, this small number of cases, and the recorded employment patterns, suggest more that the hospital was used as a shelter, or possibly a solution, by pregnant domestic servants and their mistresses, than that it was a repair shop for prostitutes.

3.2.5 Origins

Both types of Births Register were intended to record the birthplaces of all admitted mothers.[63] From Figure 3.21, it can be seen that in the four years studied, approximately 30% of all patients were natives of the City of Edinburgh, with approximately 5% from Leith, and slightly less from Edinburgh's satellite villages, now its suburbs.

Figure 3.21
Origins of All Indoor Patients at the ERMH, 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

In all four years studied, the majority of the remainder, between 35% and 50%, came from elsewhere in Scotland, presumably the result of local population movement to the expanding city. However, by 1912, in terms of hospital patients, immigration into Edinburgh appears to have been in decline. Exceptionally, in 1850 15% came from

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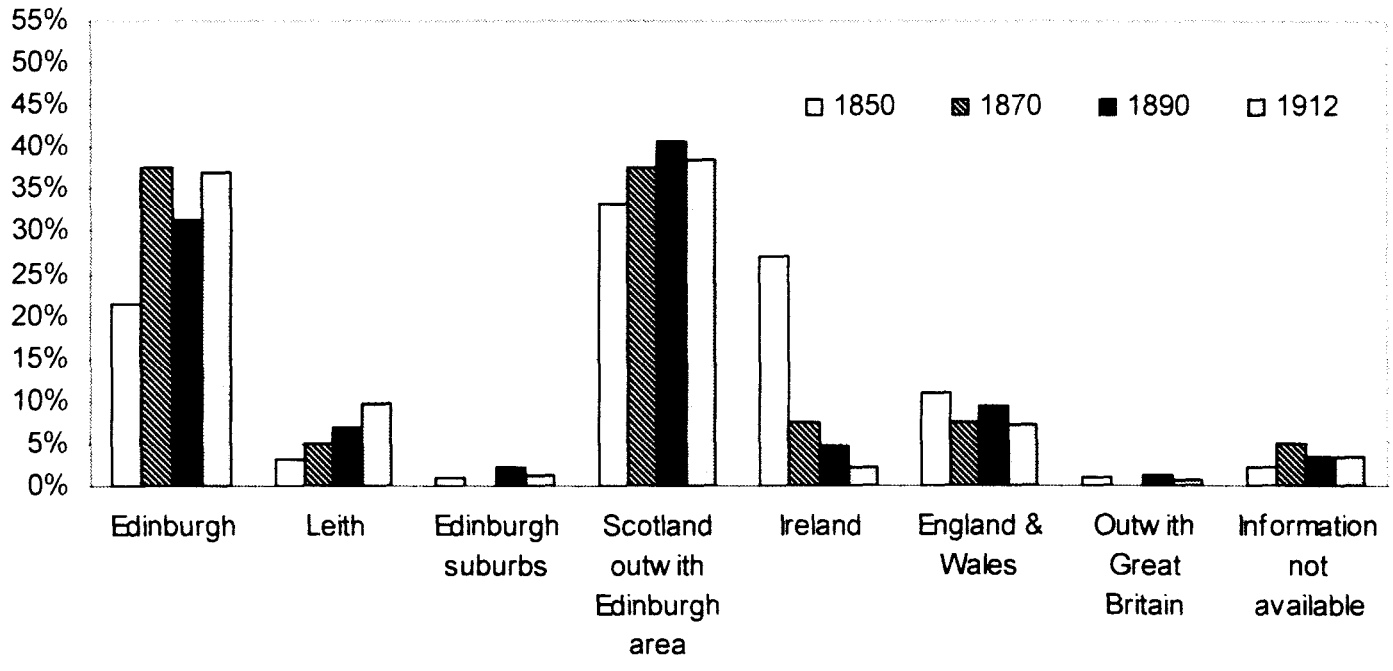
[63] In 1850 this information was recorded for 90% of patients; in 1870, 92%; in 1890, 95%, and in 1912, 94%.

Ireland, which figure had dropped to 6% in 1870, and 3% in 1890 and 1912. Approximately 8% in all years were born outside Scotland. These figures can be seen in the context of census figures for the birthplaces of Edinburgh inhabitants. In Thorburn's *Analysis of the Census of the City of Edinburgh 1851* he describes 14.5% of the population of the 'Ancient and Extended Royalties' (the Old and New Towns) as having been born in Ireland, and 40.7% as being born elsewhere in Scotland.[64] In the 1871 census, 46% of Edinburgh inhabitants were described as born 'in other counties of Scotland,' (the hospital figure being 49%), whilst 4% as born in Ireland.[65] Thus the hospital patients were representative of changes in the population of Edinburgh, especially amongst the poor. The short-term predominance of Irish in the hospital highlights the fact that its clientele came both from the very poorest in society, and from those who had no available local family support to call on during labour and the puerperium.

When these data are divided into married and single, more variation can be seen. Figure 3.22 shows the birthplaces of married inmates of the ERMH.

Figure 3.22
Birthplaces of All Married Indoor Patients at the ERMH, 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

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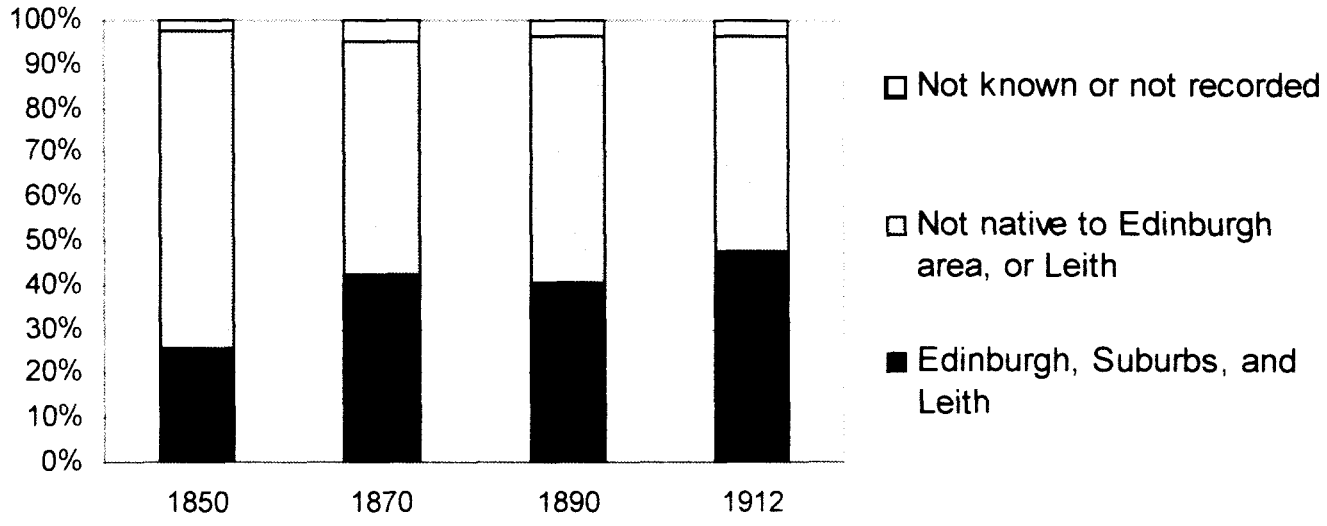
[64] Thomas Thorburn, *Analysis of the Census of the City of Edinburgh 1851* (Edinburgh: Adam and Charles Black, 1851), Table XV, pp. 40-1. In 1850, 35% of ERMH inmates came from Scotland, outwith Edinburgh.
[65] RGS, *Census of Scotland for 1871,* Table 25, p. cliii.

From this it can be seen that in 1850 the biggest grouping of married women came elsewhere in Scotland (34%). The next largest group was those from Ireland (26%), the families of 'navigators', who, according to Thorburn, were unable to return home due to the famine.[66] Only 22% were natives of Edinburgh. This further emphasises the association of lack of close home connections and support with use of the hospital by married women. It may also indicate that the hospital was not popular locally. Thereafter, the number of patients from Edinburgh and Leith gradually rose, although the trend was slow and inconsistent. Figure 3.23, which combines the figures for Edinburgh, Leith and the suburbs, shows that by 1912, 48% were local users. These figures, taken in conjunction with those on current residence, indicate increasing confidence in the hospital locally.

Figure 3.23
Birthplaces of All Married Indoor Patients at the ERMH (Simplified), 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

The picture with single women is very different (Figure 3.24). The greatest percentage of local women used the hospital in 1850, declining from a high point of 38% to only 24% in 1870. However, 1870 saw the largest number of single women born outwith Edinburgh attending the hospital, 55%. Thereafter, the number of locals increased slightly, and the fall in non-Edinburgh Scots was matched by a rise in the

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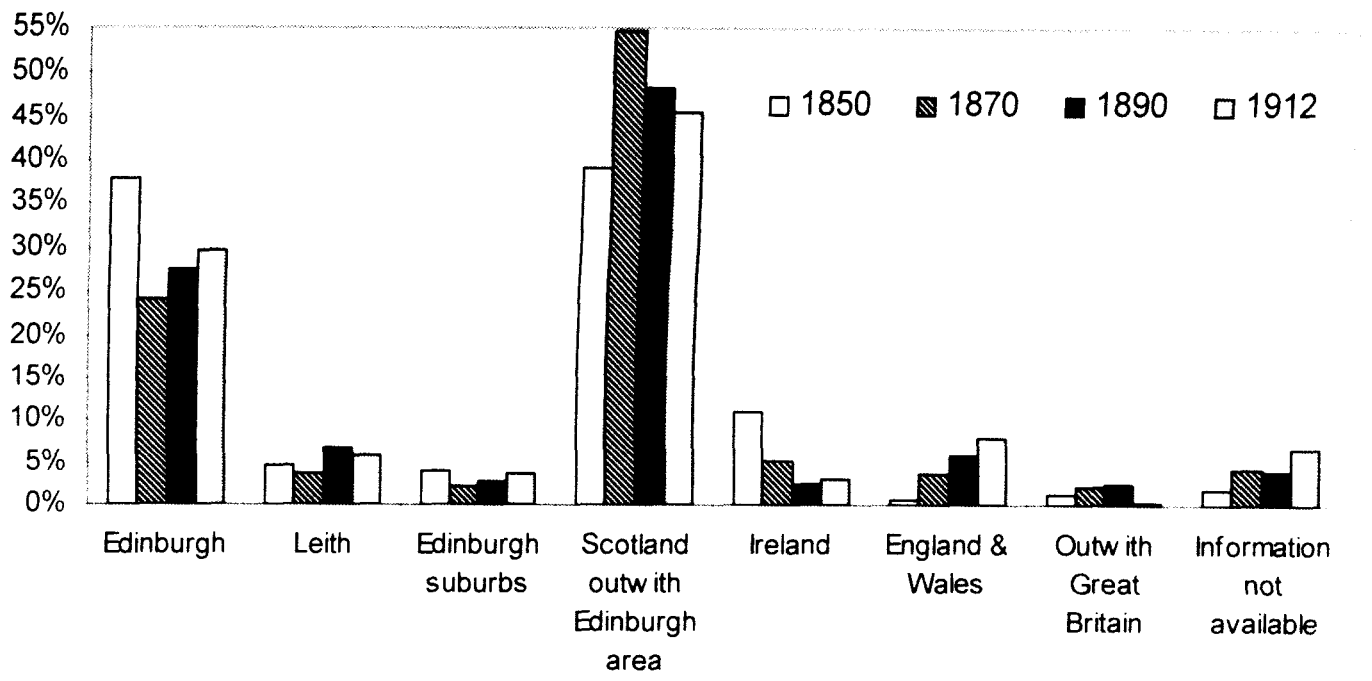
[66] Thorburn, *Statistical Analysis of the Census of Edinburgh 1851*, pp. 6-7.

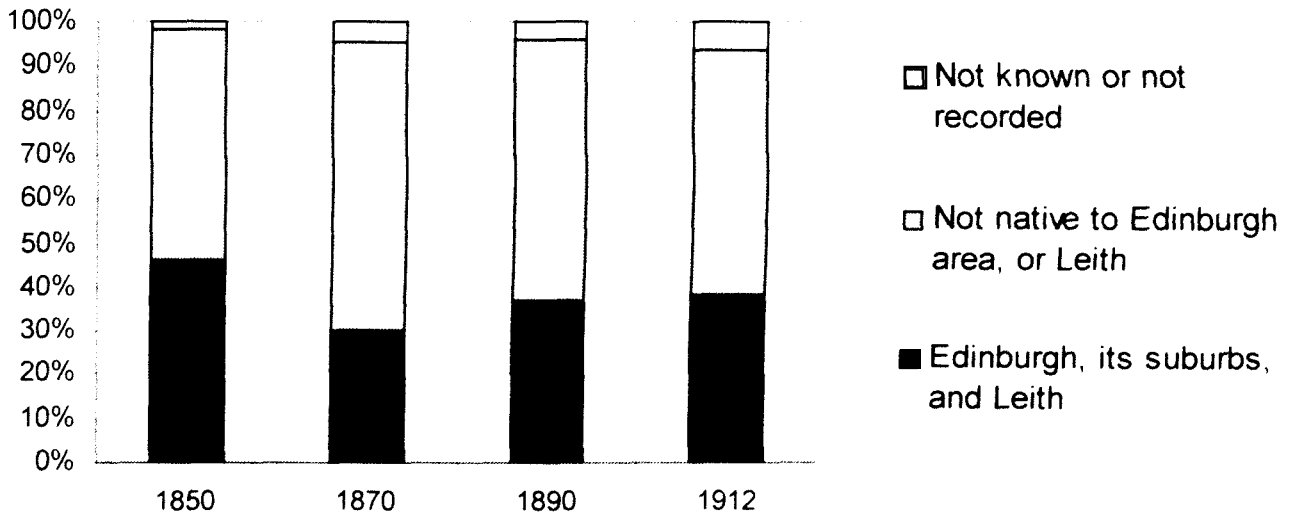
Figure 3.24
Birthplaces of All Single Indoor Patients at the ERMH, 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

number of Englishwomen. However, when the origins of single women are considered in a simplified form (Figure 3.25), it can be seen that the hospital never returned to the level of 1850, when 47% of single women were born in the Edinburgh area. By 1912, only 38% were. These figures show the influence of the 'mother and baby' homes, with their high proportion of non-Edinburgh residents, on the hospital.

Figure 3.25
Birthplaces of All Single Indoor Patients at the ERMH (Simplified), 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

Similar information for Outdoor patients is much harder to obtain, involving tracing them in the census of the following year. In 1851 Mrs Jane Milira or Milara was still living at 82 Grassmarket with her year-old daughter Ann and husband Andrew: both parents were described as having been born in Ireland.[67] Henry and Christina Perfit, who had moved from the Canongate to North Back of the Canongate following the stillbirth of their son, were both born in Edinburgh.[68] Of the four other families traced from 1851 two were from Edinburgh, one from Sutherland, and one from Ireland. In 1871, 18 families were traced; nine of the mothers were Edinburgh natives. Two were Scots, whilst the others were Irish, although not necessarily married to Irishmen. In 1891, six of the 12 mothers traced were born in Edinburgh, two were born elsewhere in Scotland, two in England, one in Ireland and one in Gibraltar as a British subject. Overall, this suggests that in the three years for which data are available, approximately half the users of the Dispensary were Edinburgh natives, in comparison to those who used the Hospital. This is in keeping with census data on general immigration into Edinburgh, and suggests that, unlike Indoor patients, in its origins the Outdoor population was typical of the city as a whole.

3.2.6 Current Residence

The hospital recorded the addresses of both Indoor and Outdoor patients. In all years about 80% of in-patients were living in the Edinburgh area, whilst 10% came from elsewhere.[69] Figure 3.26 shows the last recorded residence of married Indoor patients.

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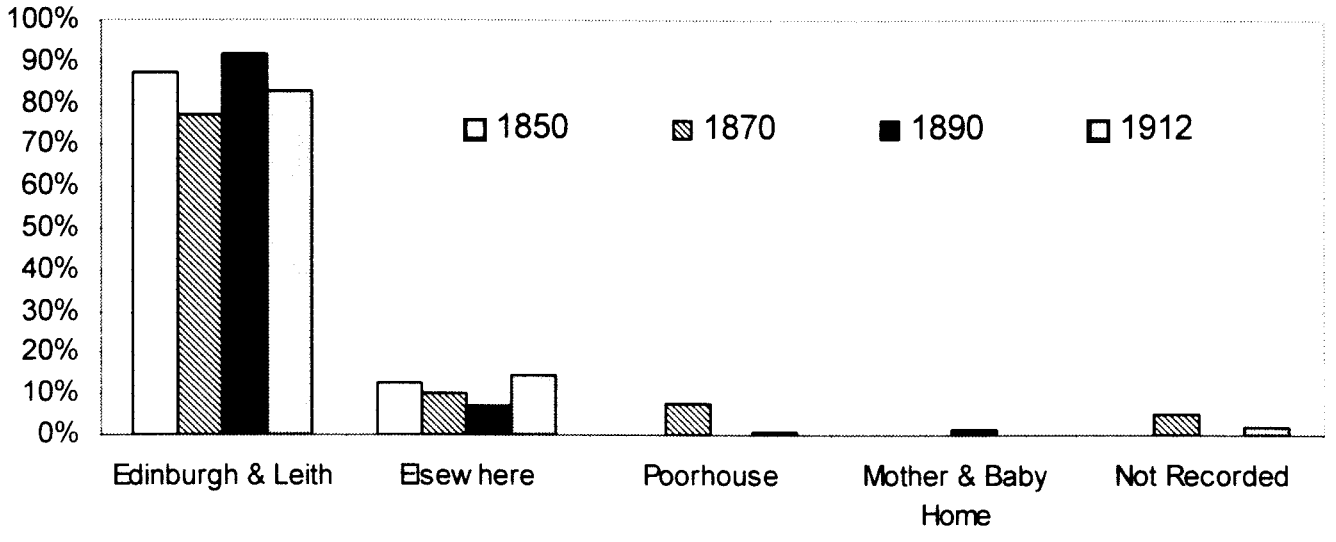
[67] 1850 OCB, case 3019 [038/3019/50fo]; RGS, *1851 Census of the City of Edinburgh,* Volume 726, Enumeration Book 2. These families were traced in the version of the census produced by the Scottish Genealogy Society. (N. R. and S. Carstairs (compilers), *Edinburgh 1851 Census*, Volume I, *The Canongate,* Volume II, *The Old Town,* (Scottish Genealogy Society, 1993)).

[68] 1850 OCB, case 2988 [010/2988/50fo]; RGS, *1851 Census of the City of Edinburgh,* Volume 742, Enumeration Book 1. This is not a complete identification, because they had moved, and obviously there was no confirmatory child in the house, but her age is correct, and the surname so unusual (they are the only two in the Genealogical Society list, and there are none in the current Edinburgh telephone directory) that identification seems almost certain.

[69] In addition, approximately 10% overall were either not recorded, or untraced.

Figure 3.26
Last recorded Residence of Married Indoor Patients at the ERMH, 1850-1912

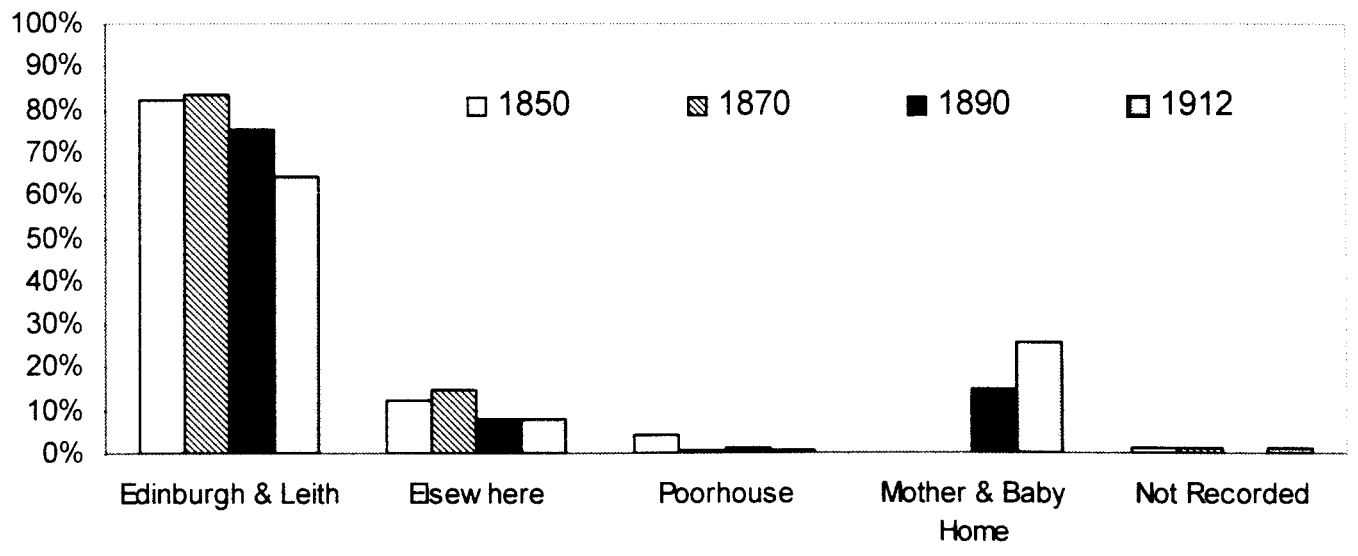


Source: ERMH Births Registers, 1850, 1870, 1890, 1912

In 1850 approximately 88% of married women gave addresses in Edinburgh or Leith. By 1870 this had fallen to 78% (excluding 8% from the poorhouse), the remainder coming from outside the Edinburgh area (10%).[70] In 1890 local women constituted 92% of Indoor married patients. By 1912 this had fallen again, to 82%, but was replaced by a rise to 14% in women coming to the hospital from outside Edinburgh.

Figure 3.27 shows similar data for single Indoor patients.

Figure 3.27
Last recorded Residence of Single Indoor Patients at the ERMH, 1850-1912



Source: ERMH Births Registers, 1850, 1870, 1890, 1912

The number of single Edinburgh residents using the hospital appeared to decline from 1870, but this was matched by the increase in residents of 'mother and baby' homes, from 14% in 1890, to 26% in 1912. Those coming from outside Edinburgh, not associated with a home, stabilised at about 9% in 1890. However, in 1912, only 17 of the 76 'mother and baby' home residents, were born in the Edinburgh area. The choice of the hospital by patients not resident in the Edinburgh area will be the focus of more detailed examination.

Thus, when ERMH patients are examined according to whether they delivered Indoors or Outdoors, they can be seen to be separated by more than their degree of poverty. Nonetheless, from the evidence of their own and their partners' occupations, almost all patients were extremely poor. However, variation is seen when the patients are further divided by their marital status, and compared to available national statistics. Indoors, married patients, a minority before 1912, were atypical in their age before that date, and although overall they followed the national trend in their parity, in most years an excessive percentage were having their first or second child. By 1912, when they constituted half the Indoor patients, both their ages and parity were similar to nationally-collected data on childbearing women. Single Indoor patients were largely typical of the national data on parity and age, although by 1912 an excessive percentage were very young. Outdoor married patients were always typical of the national data in their origins, and in their age at childbirth from 1870, but were never typical in regard to parity. The Outdoor single population was also unusual, and there is an argument for considering some of its members as married in all but name. The typical, or otherwise, nature of the different ERMH populations in terms of age and parity have significance in regard to the obstetric treatment they received, and to the experience that treating them offered the hospital's pupils.

Indoors, variations have been observed in the origins and current residence of both married and single patients. Their cases deserve detailed examination as to their motives in seeking admission, in itself an abnormal thing to do at that time. In particular, the married women who were strangers to Edinburgh, yet became Indoor

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[70] This information is not recorded in 5% of cases.

patients, deserve closer scrutiny as to whether they were admitted for medical or social reasons, as this indicates popular understanding of the purpose of the hospital. The following section combines both the available social and medical data on Indoor patients in individual years, where possible comparing this with data available on Outdoor patients of the time, to look at the motivation for seeking admission.

3.3 Potential Motives for Admission in Married Patients

3.3.1 1850

In 1850 only 24 of 93 married patients (25%) were locally born, (that is, in Edinburgh, its suburbs, or Leith).[71] A further quarter (25) were born in Ireland, ten in England, whilst one was a planter's daughter from Jamaica. In addition, 31 were born in Scotland but outside the Edinburgh area, four of whom still lived outwith Edinburgh, three in the place where they were born.[72] Thus, two-thirds of the married patients using the hospital had no family roots in Edinburgh. Many also had additional social problems, which are listed in Table 3.1.

Table 3.1

Social Circumstances of Married Indoor Patients at the ERMH, in Number of Patients, 1850

	Born Outside Edinburgh (67)	Born in Edinburgh Area (24)	Resident outwith Edinburgh in 1850 (11) [a]
Lost Father	49	15	7
Different Address for Husband	30	12	6
Temporary Absence Caused by Occupation	19	3	5
Living in Home Area	3	19	3
No Recorded Edinburgh Connection	11	0	11
Poorhouse	1	0	0

Source: ERMH Births Register, 1850

[a] These patients were also born outside Edinburgh.

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[71] Division of the 1850 patients by their marital status and then by their geographic origins has resulted in the exclusion of three women who died and whose entries in the Births Register are therefore incomplete. In addition, marital status was not recorded for 22 patients, and 18 were entered as widows, although the baby's father was alive in 10 cases. None of these cases has been included here.

[72] The origins of two married patients were not recorded. In addition, one claimed to have been born in, and still be resident, in County Cavan, Ireland. She has been excluded from Table 3.1.

The majority of those born outwith Edinburgh (49) had lost their own father, implying the break-up of their birth family. Further, almost half gave a different address for their husband, whilst five did not know his whereabouts at all. In some cases the couple were apparently separated by the husband's work, with three men being 'at sea' whilst a fourth sailor was in the couple's native Shetland. A coachman was described as living in Melrose, whilst his wife gave her address as '21 Queen Street' when she delivered three months early.[73] Two of the three soldiers' wives did not share their husband's address. Three of the four shoemakers, and seven labourers, were absent, although their wives knew the area in which they were; possibly they were on the tramp for work, or always peripatetic. Two husbands were absent for other reasons: one was in Calton Prison,[74] whilst Janet McGregor's husband Donald was in the Royal Infirmary.[75] On the whole, this group gives the impression that broken, relationships, family mobility, and poverty prevented their having a conventional childbirth in their own home, supported by their family.

However, to be born in Edinburgh did not necessarily guarantee support. Again, the majority had lost their father, and therefore, possibly, family support. Twelve of the women born in Edinburgh were living apart from their husbands, although in three cases this seems due to his employment. James Waters was a soldier stationed in Manchester,[76] whilst James Robertson was 'Steward of the brig 'Gazelle' of Leith'.[77] Alexander Mercer was a 'Hardware Merchant' in 'Kelso, en route for Tranent'.[78] In addition, Thomas Hutchison was a patient in the Infirmary.[79] However, three women may have come home for the birth, although this does not explain their use of the hospital. Two were recorded as living with their parents, the husband of one being

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[73] 1850 ICB, case 2007 [042/2007/50fi]. This was the home of J. A. Walker W.S.
[74] 1850 ICB, case 2062 [097/2062/50fi].
[75] 1850 ICB, case 2199 [109/2199/50fi].
[76] 1850 ICB, case 2172 [082/2172/50si].
[77] 1850 ICB, case 2149 [059/2149/50si].
[78] 1850 ICB, case 2197 [107/2197/50si].
[79] 1850 ICB, case 2024 [059/2024/50fi].

described as a cabinet-maker in New York,[80] whilst a third, whose husband was a shawlmaker from 'Paseley' [sic], may have been living with other family members.[81]

The occupations of the husbands of Outdoor patients, as recorded in the 1851 census, suggests a more settled lifestyle. Two were masons, two 'general labourers', whilst one was a cooper and one a 'tailor journeyman'. In addition, three couples, two of whom were born outside Edinburgh, lived in a group with other adults, which gave them access to additional domestic support, especially at the time of delivery. Philip and Margaret Clark, both Edinburgh-born, lived in Scott's Entry with their two children, her sister, who was described as a house servant, and a lodger.[82] George and Barbara Shedden, from Auchterarder and Farr respectively, lived in Milne's Entry in the Lawnmarket with their four children, a stepson, and her widowed elder brother, a ticket porter.[83] Thomas and Margaret Clifford, from Ireland, lived at 7 Blackfriar's Wynd with their year-old son and her widowed mother.[84]

The social circumstances of these two groups of married women, both resident in Edinburgh in 1850, suggest very strongly that the selection of the Hospital by its married Indoor patients was based on their lack of family ties and support. Quiroga has suggested, in her analysis of the development of the New York Asylum for Lying-In Women, that Irish immigrants to that city brought with them the expectation of medicalised care in childbirth from the staff and pupils of a maternity hospital, in their case the Rotunda in Dublin.[85] However, none of the married Irishwomen who were Indoor patients at the ERMH, came from the Dublin area, so would not be schooled in Rotunda culture. Equally, the low take-up by Edinburgh-born women in 1850 suggests that the medical advantages of attendance, if any, were not well known. However, to focus on the social reasons for admission does not

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[80] 1850 ICB, case 2105 [122/2105/50fi].
[81] 1850 ICB, case 2010 [045/2010/50fi].
[82] 1850 OCB, case 3279 [168/3279/50fo]; RGS, *1851 Census of the City of Edinburgh*, Volume 723, Enumeration Book 2.
[83] 1850 OCB, case 3423 [198/3423/50fo]; RGS, *1851 Census of the City of Edinburgh*, Volume 732, Enumeration Book 6.
[84] 1850 OCB, case 3144 [279/3144/50fo]; RGS, *1851 Census of the City of Edinburgh*, Volume 728, Enumeration Book 5.
[85] Quiroga, 'Poor Mothers and Babies', pp. 61-2.

preclude any intention based on a fear of the impending birth, whether or not it was the result of experience. Birth outcomes, largely good in this year, are not necessarily an indicator of pre-birth anxiety, and both Quiroga and Leavitt have noted that hospital or dispensary care gave poor women free access to some of the foremost obstetricians in the city, should they be needed.[86] However, such access does not explain the decision to become an Indoor rather than an Outdoor patient, given that both could call on the Professor or other senior doctors for medical help. Fears about childbirth may have played a part in the decision to attend the hospital, but the evidence suggests a minor role for this compared to social circumstances.

Nonetheless, 11 married patients were admitted who had no Edinburgh connections: they were not resident in Edinburgh, and had never been so. As such, they seem the group most likely to have come to the hospital hoping for obstetric help. However, almost half were not currently living with their husband, and seven had suffered some personal family break-up (only three were living in the area in which they were born), so they may also have seen the hospital as a place of shelter and social support rather than expertise. Two of the women did have sad obstetric histories that could have led to their seeking help. Catherine Linch, a 40-year-old collier's wife from New Lanark, had delivered one child previously, and miscarried nine. She entered the ERMH the day before she delivered a live boy after a three hour labour,[87] whilst Catherine Seymour, from Newcastle, had had three previous miscarriages before she delivered a small stillborn daughter in the hospital.[88] In addition, Betty Hogg, from Dundee, needed chloroform 'occasionally ... during the 4 hours the head was on the perineum ...'. This was her fourth baby, and it was not unduly large, so one could speculate that she had been attracted to the ERMH by a combination of potential pain relief and previous grim experience.[89]

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[86] Quiroga, 'Poor Mothers and Babies', pp. 69-7; Judith Walzer Leavitt *Brought to Bed: Child-bearing in America 1750-1950* (New York: Oxford University Press, 1986), pp. 74-7.
[87] 1850 ICB, case 2167 [077/2167/50si].
[88] 1850 ICB, case 2055 [090/2055/50fi].
[89] 1850 ICB, case 1178 [013/1178/50fi]: Baby Hogg weighed 7lbs 8oz.

Table 3.2
Obstetric Circumstances of Married Indoor and Outdoor Patients at the ERMH, in Number of Patients, 1850

	In-patients Resident outwith Edinburgh (11) [a]	In-patients Resident within the Edinburgh Area (81)	Outdoor Married patients (361)
Number of Deliveries Recorded	11	76	349
Number of Babies Born	11	78	353
Perinatal Deaths	1	6	45
Maternal Deaths	0	0	1
Labour Classified as Normal and Problem-free	9	70	320
Maternal Cause for Anxiety	2	3	3
Intervention in Labour	0	1	3
Recorded Use of Chloroform	1	1	0

Source: ERMH Indoor and Outdoor Casebooks, 1850

[a] These patients were also born outside Edinburgh.

However, Table 3.2 contrasts the delivery experiences and outcomes for both Indoor and Outdoor patients at the ERMH. Using labour classification as an indicator shows that there was little difference between the three groups. Those from outside the city were least likely to deliver normally (82%), possibly reflecting the presence of those with obstetric fears. However, those resident in Edinburgh, but currently ERMH in-patients, were most likely to deliver normally (92%). Those delivering Outdoors had a slightly higher rate of preternatural (twin and breech) deliveries than those delivering Indoors did.[90] Perinatal deaths were highest among babies born Outdoors (13%), and lowest among babies born to Edinburgh residents in the hospital (8%). It is tempting to ascribe this to the benefits of rest for the mother, but it is more likely to be multi-causal, and involve less experienced staff at delivery, the increased number of multiple births and malpresentations previously noted, as well as the lifestyle of the mother. Among hospital patients, the perinatal mortality rate among those mothers born outside Edinburgh was 9.1%; among the Edinburgh-born it was 4.5%. There was one maternal death. This occurred Outdoors, when Mrs Bryce died from pre-existing pneumonia two days after delivery.[91] There was no difference between Indoor and Outdoor cases in the use of intervention, and the recorded use of

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[90] 3.7% of Outdoor cases were so classified, compared with 2.6% among women born in Edinburgh, delivering in the hospital. The Outdoor normal delivery rate was 88.6%.
[91] 1850 OCB, case 3667 [209/3667/50so].

chloroform was minimal. Evidence of possible reasons for maternal anxiety is slight, tending to be when those fears are realised, but in each group a small number had real or potential problems in their recorded medical histories, typically prematurity, a history of stillbirth, or haemorrhage. Overall, the wretched life circumstances of those married women who chose to deliver in the ERMH in 1850 suggest that social disruption and lack of support at home influenced their choice more than access to, or need for, medicalised care.

3.3.2 1870

In 1870 only 40 of the 189 patients were recorded as married, and of these 23 were born outside the Edinburgh area, and 16 within it.[92] Three women came from Ireland, three from England, whilst the rest were Scots, eight coming from the north. A breakdown of their social circumstances can be seen in Table 3.3.

Table 3.3
Social Circumstances of Married Indoor Patients at the ERMH, in Number of Patients, 1870

	Born outside Edinburgh (23)	Born in Edinburgh Area (16)	No Recorded Edinburgh Connection (3)
Lost Father	?13	?10	?2
Different Address for Husband	12	8	?1
Temporary Absence Caused by Occupation	5	0	0
Living in Home Area	1	13	1
From Poorhouse	3	1	1

Source: ERMH Births Register, 1870

The Birth Register no longer recorded whether the woman's father was still alive, although the lack of an entry for his occupation might well imply that he was dead, in which case 13 of the women born outside Edinburgh had already lost their father, as had 10 of the 16 born in the city. Only 11 of those born outwith Edinburgh shared the same address as their husband, although again his employment was responsible for some separations. William Reddy was the House Steward at Lisfallen House, in

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[92] There is only a minimal record for one patient, which does not include her birthplace or current residence. Marital status was not recorded for nine, one was entered as 'query' although she appears to

Perthshire,[93] whilst Robert Burns was a coachman in London[94] and William Monk was a Driver in the Royal Artillery at Leith Fort.[95] Two husbands were at sea. George Foster's wife Agnes inverted the usual situation. Whilst he was recorded as a hatter, living in High Terrace, she was described as 'a wanderer' when she was brought in by the police, having aborted on a stair in the Canongate.[96] The whereabouts of two husbands were not known, the wife of one being admitted from the Canongate Poorhouse.[97] It is possible to compare the addresses for 14 of the 16 Edinburgh-born women. Eight lived with their husbands. James Gilbert's address was entered as 'not known',[98] whilst the wife of the one of the three incomplete entries was admitted from the House of Refuge.[99] Four husbands were working in England, being a tailor, a brassfounder, a joiner, and a blacksmith, but their absence may not have been temporary. In 1870, in contrast to 1850, only three married women were admitted who had no Edinburgh connections. Two had obstetric problems, but the third woman, Mrs Mary Black, a 38 year-old watchmaker's wife, and a native of Marykirk, was admitted from Dalkeith Poorhouse six days before delivery, as a result of the ERMH's prior arrangements with local poorhouses. Following a nine-hour labour, she was delivered of her fourth child by Mrs Sutherland, one of the midwives.[100] Nine days later, mother and son, both well, were discharged to the poorhouse. Again, the picture created is that the married patients who used the hospital were principally the victims of social disruption and poverty that prevented them from organising their lying-in in their own home.

As in 1850, those Outdoor patients traced appear to have had more stable lives. Two women were described in 1871 as heads of household, one being a 'fruit and fish

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have been single, and one was entered as 'Mrs', but recorded as single. There were two widows and in both cases the baby's father was still alive. None of these cases has been included.

[93] 1870 ICB, case 1706 [009/1706/70si].
[94] 1870 ICB, case 1645 [061/1645/70fi].
[95] 1870 ICB, case 1641 [057/1641/70fi].
[96] 1870 ICB, case 1725 [028/1725/70si].
[97] 1870 ICB, case 1637 [053/1637/70fi].
[98] 1870 ICB, case 1694 [090/1694/70fi].
[99] 1870 ICB, case 1668 [084/1668/70fi].
[100] 1870 ICB, case 1720 [023/1720/70si].

hawker',[101] the other having no visible means of support, her two older children being scholars.[102] One spouse had an occupation likely to lead to separation, being a soldier and not present on census night: Mrs Mary MacPhail lived with her parents and baby Helen in Oakfield Court.[103] However, the remaining 15 shared their homes with their husbands, who were variously employed in the building trade or small-scale manufacturing. One, a mattress-maker, was blind.[104] In addition, six families shared accommodation with other adults or their own older employed children, suggesting access to more domestic support and possibly income.

Table 3.4
Obstetric Circumstances of Married Indoor Patients at the ERMH, in Number of Patients, 1870

	Resident outwith Edinburgh (3)	Resident in Edinburgh Area (34)	Outdoor Married Patients (294)
Number of Deliveries Recorded	3	32	286
Number of Babies Born	3	32	290
Perinatal Deaths	2	5	40
Maternal Deaths	0	0	1
Labour classified as Normal and Problem-free	2	30	239
Maternal Cause for Anxiety	2	3	7
Intervention in Labour	1	1	4
Recorded Use of Chloroform	0	1	0

Source: ERMH Indoor and Outdoor casebooks, 1870

Again it is clear from the evidence collated in Table 3.4 that obvious obstetric reasons for admission were rare. As in 1850, comparison with Outdoor cases shows that there was little difference in delivery outcomes between Indoor and Outdoor married patients. Labour was more likely to be classified as normal Indoors (93.8%), though this is largely the result of 20 Outdoor labours being unclassified, and a

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[101] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 19; 1870 OCB, case 5326 [127/5326/70so].
[102] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 10; 1870 OCB, case 5166 [200/5166/70fo].
[103] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[3], Enumeration Book 50; 1870 OCB, case 564 [030/564/70fo].
[104] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 1. This is not a complete identification: all family details tally with those in the Outdoor Book , with the

slightly higher rate of recorded preternatural deliveries in the dispensary.[105] The perinatal death rate in both groups of Edinburgh residents was broadly similar, although in contrast to 1850, it was both higher in general, and higher in the hospital (15.6%), than Outdoors (14%). The only maternal death among married women occurred in a patient who had delivered Outdoors and unattended. The house surgeon wrote: '[f]ound a child dead about 10 days in Utero, born 10 min when I arrived. Severe p.p.hem - Detached placenta - mother had puerperal mania Jan:23 and was admitted to Maternity Hospl. on 24th.'[106] Seven Outdoor cases had cause for anxiety, usually antepartum haemorrhage, or extreme prematurity, although in three cases the woman had fallen, or been struck. Three Edinburgh-born Indoor patients had cause for anxiety: for one the Casebook entry reads '[p]atient has worn tube in Trachea for 3 years - Chloroform cautiously administered during two last pains – anaesthesia.'[107] One delivered very prematurely, whilst the third, Mrs Stewart, having her fourth child, was 'artificially induced ... & delivered by turning' under circumstances that suggest she had a severely contracted pelvis.[108] Overall, there was little obstetric difference between those Edinburgh residents delivered in their own homes, and those delivered in the ERMH. Most were in-patients for social rather than medical reasons.

However, two of the three women living outwith Edinburgh had real cause for anxiety. Both Mrs Airey and Mrs Boyle, having their fourth and fifth child respectively, had no living children, and from comments in the casebook, both anticipated problems at delivery. Mrs Boyle, aged 24 and a labourer's wife, had come from Glasgow to be delivered: her three previous children had died in infancy.[109] Dr W. Wood, the house surgeon, delivered her of a live son on 29 April, but when mother and son were discharged on 6 May the baby was described as being 'not expected to survive the day'.[110] In March Mrs Airey, 28, expecting her fourth

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exception of her surname, her name being Anne Bagan in the hospital records (1870 OCB, case 5105a [140/5105a/70fo]), but Mrs Ann Clark in the Census.

[105] Outdoors this was 3.4%; Indoors it was 2.9%. The Outdoor normal delivery rate was 89.8%.

[106] She died on 25 January. (1870 OCB, case 596 [062/596/70fo]).

[107] 1870 ICB, case 1616 [032/1616/70fi].

[108] 1870 ICB, case 1599 [015/1599/70fi].

[109] She may also have had social problems: her husband's address is 'dashed', and not recorded.

[110] 1870 ICB, case 1643 [059/1643/70fi].

child, the daughter of an engineer and presumably English, came 'from Penrith to be prematurely delivered in consequence of contracted pelvis'. Following induction she laboured for '3 to 4 days', until 'Dr Keiller dilated Os artificially, turned and extracted' a stillborn daughter.[111] These two women, plus Mrs Stewart, are the only married patients it is possible to identify clearly as being in need of skilled obstetric help and using the hospital to access it. For the majority of married women in 1870, the ERMH provided a social shelter.

3.3.3 1890

In 1890 48 of the 86 married patients were born outside the Edinburgh area, where five still lived.[112] Thirteen were not Scots: eight were English, four Irish, whilst one was Japanese, with her last address being given as 'the Japanese Village Exhibition'.[113] The married patients' social circumstances have been divided firstly by whether or not they were Edinburgh natives. The change in data collected in the Birth Registers means that information about the woman's father, or even whether she shared an address with her husband, is no longer available. However, the baby's father's occupation was still recorded for married patients, from which it can be seen that 14 spouses of those born outwith the city were engaged in occupations where accommodating a home delivery might be difficult, in contrast to only three of those married to Edinburgh natives (see Table 3.5). Overall, eight were soldiers, whilst six men were in domestic service. Two were described as 'travellers' whilst Robert Bell was an actor.[114] As in earlier years, these women were using the hospital to replace missing family support. However, the motives of the Edinburgh-born women, more likely to be living in the area in which they were born, and evidently only rarely married to men working away from home, are less clear.

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[111] 1870 ICB, case 1615 [031/1615/70fi]. Mrs Airey's record does not include her birthplace, nor her full address.
[112] Birthplace data was recorded in 84 cases, but one place was unidentified. It was not recorded in three instances where the patient died. There was one widow, who has been excluded from this analysis.
[113] 1890 ICB, case 12 CEU [118/12u/90fi].
[114] 1890 ICB, case 35 JHC [061/35hc/90si].

Table 3.5
Social Circumstances of Married Indoor Patients at the ERMH, in Number of Patients, 1890

	Born outside Edinburgh (48)	Born in Edinburgh area (35)[a]	Resident outwith Edinburgh in 1890 (6)	Resident in Edinburgh area in 1890 (80)
Born in Edinburgh	0	35	1	35
Born outwith Edinburgh	48	0	5	42
Occupation likely to Cause Residence Problems	14	3	1	17
Living in Home Area	2	27	2	27

Source: ERMH Births Register, 1890

[a] The birthplaces of three Edinburgh residents who died in the hospital were not recorded.

Although there is less recorded information on the lifestyle of Indoor married patients in 1890, this number of absent (if working) husbands implies a degree of social disruption. Nine of the 12 families traced from the Outdoor book had a more settled lifestyle. Three husbands worked in the building trade, two were in small-scale manufacturing, whilst the others included a Life Insurance Agent, a butcher in a slaughter-house, a cabman, and a coal porter, whose wife is recorded as continuing to work as a paper-sorter. Three shared their homes with other adults: in one case a boarder, but in the others, with their own teenage, employed children. However, one family was unusual. At 382 Castle Hill, Isabella Mackenzie, wife of a soldier absent on census night, lived in their home, but it was in a close shared with three other soldiers' wives.[115] In contrast to many Indoor married patients, Outdoor patients continued to have a more settled lifestyle, with easy access to adult and family support.

Table 3.6 shows the obstetric circumstances of the married Indoor patients, divided by their current place of residence, (this has the effect of including three women who died, and whose places of birth were not recorded), and contrasts these with the circumstances of the Outdoor married patients. Overall, 80 married in-patients lived within the Edinburgh area, and six outside. Two of these women had no recorded connection with the city, possibly suggesting an obstetric motive in attending the ERMH. Mrs MacLachlan, 27, born in and living in Linlithgow, came in her eighth

month and sixth pregnancy, to be induced for a known rickety pelvis. Sadly, her 6lb. 7oz. son only lived for 22 hours.[116] Mrs Bell was an English-born actor's wife, and could therefore be assumed to be peripatetic. She delivered without problems. Another woman should be in this group. A known cardiac patient, suffering from 'great anasarca and dyspnoea', Mrs Jane Thomson described herself as having come from her married home in Stockton to be delivered in the hospital which had treated her before. However, she gave an address in Portobello for her last and future residence.[117]

Table 3.6
Obstetric Circumstances of Married Indoor and Outdoor Patients at the ERMH, in Number of Patients, 1890

	Resident outwith Edinburgh (6)	Resident in Edinburgh Area (80)	Outdoor Married Patients (593)
Number of Deliveries Recorded	6	77	568
Number of Babies Born	6	79	575
Perinatal Deaths	1	(17%) 13	(10%) 55
Maternal Deaths	0	3	3
Primiparae	4	(33.8%) 27	(13%) 75
Grand Multiparae	1	(19%) 15	(35%) 210
Labour classified as Normal and Problem-free	5	54	505
Intervention in Labour/Delivery	1	16	35
Serious Delivery Problem	1	2	5
Recorded Maternal Ill health	0	(6%) 5	(1%) 4
Maternal Cause for Anxiety	1	11	17
Recorded Use of Chloroform	0	9	3
Referred by Outside Doctor/ Emergency Admission	1	6	0

Source: ERMH Indoor and Outdoor Casebooks, Special and Ordinary Casebook, 1890

From the material in Table 3.6, the ERMH appears to be on the brink of change. The general data on ERMH patients shows that, unlike the Outdoor patients, Indoor married patients were atypical of the childbearing population in age, and origins, and, to a lesser extent, in parity, and this, and their small numbers, has led to a search for

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[115] RGS, *1891 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 2; 1890 OCB, case 119 CEU [340/119u/90fo].
[116] 1890 ICB, case 38 DBH [064/38bh/90fi].
[117] 1890 ICB, case 6 JHC [032/6hc/90si].

reasons, not directly connected with childbirth, for them to seek admission. However, by 1890, a small number of local women do appear to have sought admission for medical reasons. This is apparent when Indoor and Outdoor local residents are compared. Most immediately noticeable, compared with 1870, is an increase in the numbers of interventions in labour and delivery, with a subsequent decline in normal deliveries, in both groups.[118] However, this was, in the first instance, the result of a general change in approach to the management of labour, and is discussed in Chapter 4. A better indicator of change is the increase in cases of perceived maternal anxiety, that is, when the mother and her 'friends' knew (or should have known), in advance of delivery, that there was a problem, typically heavy antepartum haemorrhage, prematurity, previous cardiac disease, or eclamptic coma. In 1890, 14% of Indoor married admissions fell into this category, compared with 3% Outdoors.[119] When this is combined with the very large rise in intervention Indoors, with the disproportionate number of times chloroform was administered to this group, and with the introduction of referrals by an outside doctor, the implication is that the ERMH was beginning to change from a shelter for the destitute pregnant, to a hospital providing specialist care for the pregnant sick. However, not all patients saw the hospital as a medical resource, and possibly resented the implications of admission. This is shown by the greater number of Outdoor patients who had serious delivery problems, yet were delivered at home. For example, when Mrs Moffat suffered a uterine rupture, after delivery, when the doctors '[t]ried ... to get her removal to hospital ... neither she nor her relatives would allow it'.[120] The nature of these Outdoor cases, which also included two abdominal operations, and the management of a placenta praevia, can be seen to be similar to the smaller number of difficult cases handled Indoors, which included two placental presentations, and delivery through a severely contracted pelvis, all admitted as a result of referral.

Further evidence of the beginning of a change in local understanding of the purpose of the hospital can be seen when the Indoor married patients are divided according to

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[118] Among Indoor married patients, the intervention rate was 20%, compared with 3% in 1870, the normal delivery rate in 1890 being 70%. Among Outdoor the equivalent rates in 1890 were 6.2%, and 89%. In 1870 the intervention rate had been 1.5%.
[119] The figures for 1870 are 5.9% Indoors, and 2.4% Outdoors.

their place of birth. Table 3.7 shows their obstetric circumstances, according to their place of birth.

Table 3.7
Obstetric Circumstances of Married Indoor Patients at the ERMH, According to Place of Birth, in Number of Patients, 1890

	Born outside Edinburgh (43)	Born in Edinburgh area (35)
Number of Deliveries Recorded	41	35
Number of Babies Born	43	35
Abortions	2	0
Perinatal Deaths	8	2
Maternal Deaths	0	1
Primiparae	16	11
Grand Multiparae	10	4
Labour classified as Normal and Problem-free	26	26
Maternal Cause for Anxiety	3	6
Intervention in Labour/Delivery	8	5
Recorded Use of Chloroform	3	2
Recorded Maternal Ill health	1	4
Serious Delivery Problem	2	0
Referred by Outside Doctor/Emergency Admission	2	2

Source: ERMH Indoor Casebook, Special and Ordinary Casebook, 1890

Married women born in Edinburgh, who have already been shown to have access to two forms of social support, as they were both living in the area in which they were brought up, and less likely to have husbands working away from home, presented with a much greater percentage of reasons for maternal anxiety (17%). This includes venereal disease, cardiac problems, eclampsia, and prematurity, and contrasts with the smaller percentage of anxious women among those born outside Edinburgh (7%), and among Outdoor patients (3%, Table 3.6). Married women born outwith Edinburgh but resident by 1890, presented with a different range of problems. Sixteen were delivering their first baby, that is 37%, compared with 31% of those born in Edinburgh. Ten of the husbands of this group had jobs that involved absence from home, in contrast to the three of the Edinburgh-born group. There were two stillbirths amongst them, (one a 4lb. 6oz. second twin), although five infants were delivered by forceps for delay or inertia. This group of primiparae appears to be well,

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[120] 1890 OCB, case 34 CEU [255/34u/90fo]; 1890 SOCB p. 76.

and using the hospital as a substitute for the social support of their family and friends. However, the category of married women born outwith Edinburgh also boasted the largest proportion of grand multiparae, (23% as opposed to 11% among Edinburgh natives). These present a combined picture of poverty and obstetric problems. General labouring was the commonest recorded occupation of the husbands. Four of the ten women concerned delivered stillbirths, whilst another haemorrhaged whilst aborting, and one of the two serious delivery problems recorded among Edinburgh residents was both a grand multipara and born outwith Edinburgh. Thus the married women who used the ERMH in 1890 represent a halfway stage: some still considered it to be a social substitute for family support, whilst others turned to it for obstetric assistance and care.

3.3.4 1912

By 1912 married patients were almost equally divided between those who were Edinburgh natives and those who were not, whilst approximately a quarter of those who were born outwith Edinburgh, still lived outside the area. Of those who were not Edinburgh natives, 124 (79%) were Scots, 23 of the remainder being English, seven Irish, whilst one was born in India and another in Hamburg.[121]

Table 3.8
Social Circumstances of Married Indoor Patients at the ERMH, in Number of Patients, 1912

	Born outside Edinburgh (164)	Born in Edinburgh area (155)[a]	Resident outwith Edinburgh (45)	Resident in Edinburgh (278)
Born in Edinburgh	0	155	8	148
Born outside Edinburgh	164	0	37	125
Occupation Likely to Cause Residence Problems	18	13	3	26
Living in Home Area	17	131	16	128
Previous Edinburgh Connection	33	155	10	278

Source: ERMH Births Register, 1912

[a] The birthplaces of four patients, three of whom died in the hospital, were not recorded.

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[121] 15 patients have been excluded from this analysis and that on single patients in 1912. Five patients were not entered in the Births Register, and therefore marital status was not recorded. Nine were called 'Mrs', of whom eight worked themselves, which in the post-1877 Births Register excludes any reference to a husband, whilst one, not called 'Mrs', but nonetheless a grand multipara admitted for manual removal of placenta after delivery, was described as 'at home'. Dual surnames were used on seven occasions. Two of these women died, and the record was left uncompleted.

As can be seen in Table 3.8, by 1912 the husband's occupation had become a less decisive factor in the choice of place of confinement. Only 18 of those men whose wives were born outside Edinburgh (11%), had occupations where accommodating a confinement might have been difficult. Eight were soldiers, three were in domestic service, all as gardeners, whilst three were 'travellers' and four went to sea. However, in contrast to 1890, 8.4% of those whose wives belonged to Edinburgh had similar occupations: three were soldiers, but three were in potentially residential service, six were sailors, and one was a traveller. No census information is available on the social circumstances of individual Outdoor patients to permit a comparison. Only three husbands (4.4%) of those not resident in Edinburgh might have had accommodation difficulties, a coachman, a gardener from Borthwick, and a fisherman, compared with 9.4% of Edinburgh residents. However, since 1890 there had been a large percentage increase in the number of patients attending the hospital who had no Edinburgh connection, and, as will be shown, this group suffered an extremely high proportion of obstetric problems.[122] Overall, and in contrast to the earlier years studied, by 1912 married patients' social circumstances provided a minor reason for hospital admission. This is illustrated by the story of Mrs H of Yeaman Place, who was evidently considered unusual in that, having been safely delivered Outdoors, she was '[b]ecause of poverty brought into Hospital.'[123] The social circumstances of the married patients in 1912 combine with the general data on their age, which by then was typical of the childbearing population, to suggest that the ERMH was now seen as a source of obstetric help, rather than social shelter.

Table 3.9, which contrasts the obstetric circumstances of Indoor and Outdoor married patients, illustrates clearly the changing function of the ERMH. Among Edinburgh residents admitted to the hospital, the intervention rate at delivery was 20.1%; in the Main Dispensary it was 2.6%, whilst in Leith it was 1.9%. Even more telling, in contrast to 1890, no serious delivery problems were tackled Outdoors, but the patients were transferred to hospital without any recorded objection by them. This happened in three cases. For example, 'Dr Bloom... Junior H.S. ... (locum) ... was

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[122] In 1890 7.5% of Indoor married patients were in this category; by 1912 it was 16.2%.
[123] 1912 ICB, case 28 JHC [496/028/hc/1912i]. Patients' surnames from 1912 have been coded.

called down to Leith with the message that there was a "breech presentation" & that pat[ient] was making no progress. On arrival a shoulder position was diagnosed & ... the case was sent up to the R.M.H.' There, Isabella P, Mrs B, was anaesthetised and delivered by internal podalic version with '[c]onsiderable difficulty ... foetus very large ... considerable force ... [necessary]. Pat[ient] suffered a little from shock that under treatment responded well.'[124]

Table 3.9
Obstetric Circumstances of Married Indoor and Outdoor Patients at the ERMH, in Number of Patients, 1912

	Resident outwith Edinburgh (45)	In-patients Resident in Edinburgh Area (278)	Outdoor Patients (Main Dispensary) (811)	Outdoor Patients (Leith Branch) (474)
Number of Deliveries Recorded	44	262	785	457
Number of Babies Born	45	269	800	463
Abortions (not included in Deliveries)	1	16	26	17
Perinatal Deaths	26	49	35	22
Maternal Deaths	11	8	0	0
Primiparae	13	64	68	39
Grand Multiparae	8	60	279	141
Labour Classified as Normal and Problem-free	5	175	567	343
Maternal Cause for Anxiety	27	22	29	5
Intervention in Labour	32	56	21	9
Recorded Use of Chloroform	13	15	11	10
Recorded Maternal Ill Health	7	13	4	0
Serious Delivery Problem	17	42	0	0
Maternal Ill Health Post-Delivery	16	19	2	3

Source: ERMH Indoor and Outdoor Casebooks, Students' External Casebook (Leith Branch), Special and Ordinary Casebook, 1912

The casebook data suggest that in previous years the hospital staff would have been sent to her home to treat such a case. Further, again in contrast to earlier years, no mother died in the care of either the dispensary or the Leith Branch.[125] Maternal ill-health was also recorded in only four Outdoor cases, all from the dispensary. One

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[124] 1912 Students' External Casebook (Leith Branch) [SECB(LB)] case 22 [22/22/1912/Leith]; 1912 SOCB pp. 6-7. See also 1912 ICB, case 74 FWNH [74/074/hault/1912i]; 1912 OCB, case 103 [103/103/hault/1912o].
[125] However, it should be noted that three dispensary patients did die after transfer.

mother had pneumonia when she went into labour, and one phthisis; one developed postpartum eclampsia and was later admitted, whilst the last had mitral incompetence, only diagnosed following her collapse at the end of her delivery. However, she was not admitted, and was discharged well on the ninth day after the birth. Overall, the Outdoor services were now geared to treating well women in labour and the puerperium, and transferred to in-patient care those patients who did not meet this description.

The change in understanding of the function of the ERMH is also seen in the increase in the hospital in the number of married patients who had no Edinburgh connection, of whom the great majority now had serious health problems. In 1912, 45 patients had no Edinburgh connection, that is, 13.9% in contrast to 7.5% in 1890, when most of the women in this category also had no obvious health problems. The data concerning this category of patients in 1912 is very distinctive, and generally indicates the obstetric need of the women, and thus their probable reason for admission. Only five of the group of 45 had no recorded problems during their stay. The intervention rate in this group was 71.1%, compared with 20.1% among in-patients resident in Edinburgh. Chloroform was used in 28.9% of their cases, compared with 5.4% in the case of other inmates, and less than 2% Outdoors. Unsurprisingly, reasons for maternal anxiety (haemorrhage, eclamptic fits, appalling obstetric history) can be found in 60% of these women, in contrast to 7.9% of other in-patients, and less than 4% of Outdoors patients.

Despite the presence in this group of five women for whom the ERMH must have been their last hope of having a live child after several attempts, this category also contained the largest group of primiparae of any of the Indoor and Outdoor divisions of married patients. Thirteen women with no Edinburgh connection were delivering their first child. However, even this group appears to have sought admission on medical grounds: only two delivered normally without problems. For example, three suffered from eclampsia, and two from contracted pelvis. Mrs L, showing 'signs of extensive rickets, ... only ... able to go about on crutches', was induced in her

seventh month,[126] but Mrs R was admitted 'after labour had lasted for 3 days ... [as] Dr Cross thought the promontory was marked'. Ultimately she was delivered by craniotomy.[127] Mrs M of Kinlochleven suffered from chorea gravidarum, dying the night after her admission and delivery.[128] Overall, a quarter of patients resident outwith Edinburgh died in the hospital, when the maternal mortality rate among other in-patients was 2.9%. Their perinatal mortality rate was 57.8%, compared with 17.6% among Edinburgh residents Indoors, and approximately 4.5% Outdoors.

Two further histories, one successful and one not, illustrate the changing function of the hospital in the eyes of both its clients and their doctors. Mrs B of Lumphinnans was recommended to the hospital by Dr Young, Cowdenbeath, 'because she wished if possible to have a living child', following a difficult forceps delivery and stillbirth, and a craniotomy. She was delivered by pubiotomy, after a trial of forceps, and was discharged with her son six weeks later, 'walking with confidence and no pain'.[129] However, Mrs Bj was less fortunate. She was recommended by Dr Anderson of Bonnyrigg, by reason of '[d]ifficulty with previous labour 10 yrs ago', when she had been attended by Dr Joss of Denny. From the outset of the consultation, Anderson '[w]ishe[d] to know if Caesarean Section necessary', implying that in a complicated case, he saw his role principally as a conduit to specialist care. Unfortunately, Mrs Bj went into spontaneous labour before her admission date, and laboured sufficiently long before her operation for 'some septic infection [to have] occurred'. She died of heart failure and infection, whilst her daughter could not be resuscitated. Due to 'Scopolamine & Morphia poisoning ... [she] failed to establish proper respiration'.[130] All these cases show that the ERMH was now looked on as a source of medical expertise and hope by patients and their doctors in a wide geographical area, but that it was not always successful.

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[126] 1912 ICB, case 141 AHFB [285/141/barb/1912i]; 1912 SOCB, p. 162.
[127] 1912 ICB, case 29 JHC [497/029/hc/1912i]; 1912 SOCB, pp. 210-1.
[128] 1912 ICB, case 49 FWNH [49/049/hault/1912i]; 1912 SOCB, pp. 42-4.
[129] 1912 ICB, case 118 FWNH [118/118/hault/1912i]; 1912 SOCB, pp. 93-6.
[130] 1912 ICB, case 125 FWNH [125/125/hault/1912i]; 1912 SOCB, pp. 97-101.

In 1890 a distinction could be made between the social and obstetric circumstances of women born in and outside Edinburgh. In 1912 this was less clear and had become slightly paradoxical (Table 3.10).

Table 3.10
Obstetric Circumstances of Married Indoor Patients at the ERMH, according to Place of Birth, in Number of Patients, 1912

	Born Outside Edinburgh, now Resident (125)	Born in Edinburgh area (154)
Number of Deliveries Recorded	115	148
Number of Babies Born	117	151
Abortions (not included in deliveries)	10	6
Perinatal Deaths	19	31
Maternal Deaths	2	4
Primiparae	31	33
Grand Multiparae	31	30
Labour classified as Normal and Problem-free	78	93
Maternal Cause for Anxiety	22	23
Intervention in Labour	25	32
Recorded Use of Chloroform	9	8
Recorded Maternal Ill Health	5	9
Serious Delivery Problem	12	12
Maternal Ill Health Post-delivery	10	13
Referred by Outside Doctor/ Emergency Admission	16	16

Source: ERMH Indoor Casebook, Special and Ordinary Casebook, 1912

As in 1890, although to a lesser degree, the group not born in Edinburgh contained the greater proportion of both primiparae and grand multiparae.[131] Possibly reflecting the higher proportion of primiparae, this group also had a higher consumption of chloroform (routinely used to treat eclamptics), and a higher incidence of maternal anxiety, inferred from a count of incidences of haemorrhage, eclampsia and prematurity in the group. Each group had the same number of serious delivery problems and a similar percentage of interventions in labour and delivery. Despite this, normal problem-free delivery was more likely among those born outwith the city. In contrast to 1890, those in-patients born in the city themselves had higher maternal and perinatal death rates, possibly hinting at a decline in the health of the

[131] 24.8% primiparae compared with 21.4% among Edinburgh natives, and 24.8% grand multiparae compared with 19.5%.

city's residents, quite plausibly the generation born around 1890. However, the reduced variation in married in-patient groups resident in Edinburgh, combined with the increasing correlation between their ages and those of the national data, suggests that by 1912 married patients chose the ERMH for the medical treatment offered rather than any shelter it could offer.

The very small amount of detailed evidence of married patients' social background also suggests a slightly widening social range of patients at the ERMH, compatible with its increasing medical role. However, among the husbands, poorly paid occupations still predominated, as shown in Figure 3.27 (Section 3.2.6). For example, although she had fallen on hard times, Mrs R 'until a year ago was a famous swimmer. When 16 years old she won a cup as champion lady swimmer of Scotland. She used to teach swimming at various Baths until 2 years ago'. However, now her '[s]ocial conditions: are bad - Husband out of work and a waster. Pat[ient] does not get enough of good food. She earns a little money from washing clothes. Finds it very hard work indeed to feed her children.'[132] Nonetheless, she sought admission because she was bleeding heavily from a placenta praevia, rather than because of her social circumstances. In contrast, Mrs G of Morningside was described by her husband, a clerk, as 'has always been very healthy & athletic. Enjoys much fresh air & perhaps overdoes (!) golf as a sport. She is always jolly but with a tendency apparently to the neurotic type ... leads a regular life. Up to time of illness she had been taking moderate exercise & taking food well.' She had engaged both her family doctor and a 'trained nurse' for her confinement at home, but when she developed '[f]its associated with pregnancy', Dr Martin arranged her admission.[133] Similarly Mrs M, a railway worker's wife, was to have been attended by her doctor and a midwife. In labour, the doctor had 'called on her often & examined her often to see if she was making any progress but as she was not getting on any further he was afraid that "there was some obstruction" so left patient to her own resources. The midwife called in therefore Dr. Carmichael who ... at once sent

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[132] 1912 SOCB, pp. 111-13.
[133] 1912 SOCB, pp. 90-2.

her in to the Maternity Hospital.'[134] These examples not only show that illness was forcing those who would not normally have considered using the ERMH to do so (possibly as a result of the new use of more intensive and therefore more expensive treatment), but also that it was becoming a resource for health professionals in Edinburgh and beyond.

By 1912, medical reasons for admission predominated amongst the married women who used the ERMH. Comments from the casebooks also support the theory that the hospital now had a reputation as a centre of expertise to which difficult cases could be referred by general practitioners in Scotland much more routinely than in earlier years. The ERMH had moved from providing a shelter to married women unable to organise a conventional lying-in for themselves, to an establishment that provided a significant minority with necessary medical care that they could not provide independently.

3.4 Potential Motives for Admission in Single Patients

The motives of single patients attending the ERMH have also been examined in more detail, based on their origins and current residence. It has been suggested, principally of English maternity hospitals, that they provided private care for those delivering illegitimate babies secretly. This interpretation of their function seems at odds with descriptions (previously examined) of mid-nineteenth century attitudes to the later legitimisation of children, and to marriage when economically justified, among the rural poor in eastern Scotland. This section examines the social and obstetric data available on single Indoor patients at the ERMH for their reasons for seeking admission.

3.4.1 1850

In 1850 the single patients were almost equally divided between those born in and outwith Edinburgh, with 17 of the latter still living outside the city. Their social circumstances can be seen in Table 3.11.

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[134] 1912 SOCB, p. 202. Dr Norman Carmichael had been a house surgeon at the ERMH.

Table 3.11
Social Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1850

	Born Outside Edinburgh (81)	Born in Edinburgh area (72)	Resident outwith Edinburgh Area in 1850 [a] (17)
Lost own Father	53	48	14
Living with Baby's Father	?7	9	?5
Possible Temporary Absence Caused by Occupation	8	4	3
Living in Area of Birth	11	64	11
Poorhouse	3	4	0
No Recorded Edinburgh Connection	15	0	15
Father's Whereabouts Unknown	8	5	1
Father's Whereabouts Not Recorded (Excludes Unknown)	3	0	2
Father Unknown	2	0	1

Source: ERMH Births Register, 1850

[a] These patients are also included in the 'born outside Edinburgh' group.

As with the married patients, these were women with few social supports. In both categories, those born within the Edinburgh area and those born without, the majority had already lost their own father, and thus their own home was possibly already broken up; in six instances, the baby's father was also already dead. Few lived with the father of their child, although in some cases this may have due to his employment, and in some the record is not quite complete. However, in 13 cases his whereabouts were recorded as unknown, as opposed to not being recorded. Fifteen of those living outwith the Edinburgh area had no recorded connections with the city, with the implication that they had come to the hospital to keep their condition a secret. One woman had come from Aberdeen. Unfortunately, the length of her antenatal stay was not fully recorded, but she appears to have been admitted some three months before delivery, although the ERMH Rules only permitted admission two weeks before the expected date of delivery.[135] Two other women in this group were admitted more than 14 days in advance of the birth. Helen Brown from Dunfermline was admitted 27 days before: her partner had died, and this might have

[135] *Rules and Bye-Laws of the Edinburgh Maternity Hospital* (Edinburgh: Andrew Murray, Printer, Milne Square, n.d.), 'Patients', Rule 2.

been considered an extenuating circumstance.[136] Eliza Danial from 'Karkaldie' [sic] was admitted 16 days before she delivered, which might have been the result of postmaturity or miscalculation.[137] However, Ann Smith, who '[s]tates she was forced by some unknown person in the country at 11 at night', was admitted five days before the stillbirth of her child,[138] and other patients with no Edinburgh connections also appear to have been admitted only one or two days before the birth, which suggests that for them local secrecy was a minor consideration. Five of these women's fathers were engaged in agricultural work, compared with nine employed in industry.

Like the married women, the single women had few obstetric reasons for admission, as can be seen in Table 3.12.

Table 3.12
Obstetric Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1850

	Born Outside Edinburgh, Now Resident (62)	Born in Edinburgh Area (72)	Resident outwith Edinburgh (17)
Number of Deliveries Recorded	56	68	14
Number of Babies born	56	68	14
Perinatal Deaths	10	12	4
Maternal Deaths	0	1	0
Labour Classified as Normal	48	55	13
Maternal Cause for Anxiety	3	1	1
Intervention in Labour	1	1	1
Recorded Use of Chloroform	1	0	0
Recorded Maternal Ill Health	2	1	0

Source: ERMH Indoor Casebook, 1850

Among those born elsewhere, but now resident in Edinburgh, two could reasonably have been anxious about the ante-partum haemorrhages they suffered, whilst one went into labour prematurely. Chloroform, the use of which might indicate an obstetric problem, was recorded as being used once, for a German patient who delivered unassisted. Two Edinburgh residents were delivered by forceps, one of

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[136] 1850 ICB, case 2032 [067/2032/50fi].
[137] 1850 ICB, case 2177 [087/2177/50si].

whom died three days later, but normal deliveries predominated. Overall, there is nothing in any of the three divisions of single mothers by birth or residence that suggests that they saw the ERMH as anything other than a social shelter. However, it should be noted that among the single women in 1850 the perinatal mortality rate was higher than among the married patients, possibly reflecting a more stressful ante-natal period. Among married mothers born outside Edinburgh, one child in eleven died around birth; among those born in Edinburgh, one in 22 did. However, among single women resident in Edinburgh, wherever born, approximately one child in six died, as can be seen in Table 3.12. Among those with no Edinburgh connection, approximately 29% of the babies died. However, since this comprises four babies only, it is difficult to draw conclusions about the effects of maternal lifestyle. Two of these babies weighed slightly more than 2lbs., and were thus non-viable, (and one was also recorded as being premature), but the other two weighed approximately 7lbs., implying that they had not been deprived *in utero* due to their mother's circumstances. In one case, the mother 'fell down stairs and that is supposed to have been the cause of this child's death'.[139]

3.4.2 1870

In 1870, too, single women were drawn to the hospital in search of social support. However, there was a marked decline in use of the hospital by those born in Edinburgh (Table 3.13). There was also a slight increase, from 10% to 11%, in those using the hospital who had no recorded Edinburgh connection, compared with 1850. Family break-up is again suggested by the number of paternal deaths recorded of those from outside Edinburgh, (although, as with the married women, this information was less well-kept), and possibly by the social mobility shown by the move of 71 women born elsewhere, into Edinburgh and Leith.[140]

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[138] 1850 ICB, case 2234 [144/2234/50si].
[139] 1850 ICB, case 2234 [144/2234/50si].
[140] The current residence of two women born outwith Edinburgh is not recorded.

Table 3.13
Social Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1870

	Born Outside Edinburgh (90)	Born in Edinburgh Area (40)	No Recorded Edinburgh Connection [α] (14)
Lost own Father	9	1	1
Fate/Occupation of own Father not Recorded	41	16	7
Living with Baby's Father	3	3	0
Possible Temporary Absence Caused by Occupation	15	5	1
Living in Area of Birth	9	38	8
Poorhouse	1	0	0
Father's Whereabouts Unknown	[β] 8	[γ] 2	[δ] 1
Father's Whereabouts not Recorded (Excludes Unknown)	14	6	5
Father Unknown	2	0	2
Father not Recorded	2	2	1
Resident outwith Edinburgh	17	0	14

Source: ERMH Births Register, 1870

[α] These patients are also included in the 'born outside Edinburgh' group. Three are excluded because the baby's father had an Edinburgh address.
[β] In addition, three fathers were in America.
[γ] In addition, one father was in America.
[δ] In addition, two fathers were in America.

The same number of both those born within and outwith the city lived with the father of their child, but a larger number of those born in Edinburgh were possibly separated by his occupation. However, a greater proportion of those born outside the area did not know the whereabouts of the father, or his identity. Again a number of single patients had no Edinburgh connection, and more than half of these were still living in their home area. However, none lived with the baby's father, and two of this group were the only women not to identify a putative father. Taken together, this does suggest the use of the hospital to maintain local secrecy. Antenatal stays can be calculated for all 14 of those not connected with Edinburgh, and these apparently ranged from 64 days before the birth,[141] to admission following an abortion. Four patients were admitted more than 14 days before delivery. Two, admitted more than

[141] This is from Birth Register evidence. The Special and Ordinary Casebook describes her as being admitted in labour (1870 SOCB, p. 6).

five weeks before, came from Callender and 'St. Boswalds' [sic] respectively,[142] again implying privacy, but three were admitted in labour, with no further history given. Possibly they had some other unrecorded accommodation in Edinburgh until they showed signs of labour. In support of this, Catherine White, from Dunbar, was recorded as staying with her aunt in the Grassmarket prior to the birth.[143] The social evidence suggests that in 1870 at least five single patients were using the ERMH to conceal evidence of their pregnancy from their 'neighbours'.

Table 3.14 shows the obstetric circumstances of single women attending the ERMH.

Table 3.14
Obstetric Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1870

	Born Outside Edinburgh (90)	Born Outside Edinburgh, but Resident in 1870 (71)[γ]	Born and Resident in Edinburgh area (40)	No Recorded Edinburgh Connection (14)[β]
Number of deliveries recorded	88	70	40	13
Number of babies born	90	72	41	13
Perinatal deaths	[α]11	10	6	[α]1
Maternal Deaths	0	0	1	0
Primiparae	54	40	22	11
Labour classified as Normal and Problem-free	75	59	24	12
Maternal Cause for Anxiety	4	3	1	1
Any Intervention in Labour/ Delivery	6	5	3	1
Recorded Use of Chloroform	4	3	2	1
Recorded Maternal Ill Health	2	1	2	1

Source: ERMH Indoor casebooks, 1870

[α] Excludes one child described on discharge as 'syphilitic'.

[β] These patients are also included in the 'born outside Edinburgh' group. Three are excluded because the baby's father had an Edinburgh address.

[γ] Two current residences are not recorded, and therefore excluded.

Five mothers had reason for anxiety before delivery: in most cases, this was the premature onset of labour, but in one case a single girl, who had intended to be delivered in her own home, was transferred into the hospital in obstructed labour.

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[142] 1870 ICB, case 1587 [003/1587/70fi]; 1870 ICB, case 1728 [031/1728/70si].
[143] 1870 ICB, case 1787 [090/1787/70si].

She, and her baby, died.[144] Four mothers were also ill: two had syphilis, whilst one had phthisis, and one was described as having had '[o]ne convulsion ... at end of 3rd Stage - Sent to Infirmary with Scarlatina'.[145] Few labours were classified as other than normal: there were a total of nine interventions, including artificial rupture of membranes, digital dilatation of the os, and four forceps deliveries. Chloroform was used five times before the birth, for one dilatation, a forceps delivery and in three normal deliveries. Again, there appear to be few obstetric reasons for admission. Dividing the single patients by their origins and current residence produces few differences.[146] Slightly over half of both those born within and outwith the city were primiparous, bearing their first child to approximately term: these were all women who claimed that they could identify the father, but were unlikely to be living with him. There was also little difference in their recorded perinatal mortality, in which one in seven to eight babies would die around birth. Amongst the 14 who had no Edinburgh connection, 11 were primiparous, whilst the remaining three were having their second child. This reflects the social picture that they were using the hospital to deliver a first illegitimate child in some privacy. As a group, they experienced few problems in labour, although one had already aborted on admission, and one had syphilis. In contrast to 1850, there was only one perinatal death among the 13 births, the result of the only difficult delivery. Seven of the 37 babies born to married women in the hospital died around birth, due in part to the obstetric problems of three mothers, but suggesting that, in contrast to 1850, the married state conferred little protection on the babies.

3.4.3 1890

In 1890, 207 single women attended the ERMH as in-patients. As with the married patients, the change in design of the Births Register has reduced the amount of data available. It is no longer possible to know whether they potentially had no family support, whether they could identify, or lived with, the baby's father, or even

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[144] 1870 ICB, case 1737 [040/1737/70si].
[145] 1870 ICB, case 1749 [052/1749/70si].
[146] However, it does 'lose' three patients whose only contact with Edinburgh was that it was where the baby's father lived, and two whose current residence was not recorded.

whether they were admitted in accordance with the hospital rules or not. Table 3.15 shows the available social data for them.

Table 3.15
Social Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1890

	Born Outside Edinburgh (122) [a]	Born in Edinburgh Area (77)	Resident Outwith Edinburgh (18)	Resident in Edinburgh Area (189)
Born in Edinburgh	0	77	0	76
Born outwith Edinburgh	122	0	18	105
Living in home area	6	64	7	57
From the Poorhouse	2	1	1	2
No recorded Edinburgh Connection	4	0	7	0
Described as Domestic Servant	87	37	15	116
Resident in 'Mother and Baby Home'	22	6	3	30
Domestic Servant and from 'Mother and Baby Home'	16	5	3	23

Source: ERMH Births Register, 1890

[a] The birthplaces of eight single women were either not recorded or not known.

It can be seen from Table 3.15 that 61.3% of Indoor single patients were born outwith Edinburgh, typically coming from elsewhere in Scotland, although 12 were English, five Irish, and five came from outwith Great Britain. These included a 21-year old Swiss sewing maid, and a 14-year old German girl. By 1890, 91.3% were living in Edinburgh, illustrating the large migration into the city of single women seeking work. The great majority were employed as domestic servants: 80, or 65.6% of those born outside the city, were employed as such in Edinburgh; 83.3% of those born and living outwith the city were also servants.[147] This high percentage of domestic servants can be compared with the census figures for female employment in Edinburgh in 1881, when 21% were in the class that included domestic service. Both Horn and Bartley have commented on the sexual vulnerability and lack of support of young girls in service,[148] and the hospital data appears to illustrate this.

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[147] These figures exclude the four women who worked as barmaids, only one of whom was born in Edinburgh, and the two who were waitresses, one of whom was from the city, although all three jobs have the same census classification.
[148] Horn, *The Rise and Fall of the Victorian Servant,* pp. 152-5; Bartley, *Prostitution: Prevention and Reform*, pp. 3-7.

The possible lack of family support for single pregnant girls is emphasised in 1890 and after, by the new use of 'Mother and Baby' homes. Five of these have been identified from patients' address records. Four were situated extremely close to the hospital. The largest was the Alice Home at 12 Lauriston Park. This home was the only one given its title in the Births Register, the existence of the other homes being deduced from duplicate addresses. During 1890, 14 patients came from the Alice Home. It was described on census night 1891 as having a matron, Miss Jane Bishop, aged 57, and three apparently ante-natal inmates, all domestic servants, two in their teens, only one of whom was born in Edinburgh.[149] The other homes were 94 Lauriston Place (eight patients), 16 Glen Street (six patients), 7 Dunbar Street (two patients), and, slightly further away, 20 Cathcart Place, Dalry (three patients). The earliest description of such homes in the ERMH records dates from 1907, and is discussed in the next section. Nonetheless, it seems reasonable to extrapolate that a financial charge was made, as was an attempt to find inmates new employment and childcare, and to provide long-term supervision. However, it can be seen from Table 3.16 that in 1890 admission was not limited to those having their first child. Table 3.15 shows that 33 single women, 16% of the whole, used such homes before and after delivery, but that majority of users were born outside Edinburgh. The significance of this is unclear, although McCalman has suggested that at the Royal Women's Hospital, Melbourne, locals had easier access to family support, were unable to tolerate the social control of that institution, and therefore did not apply.[150] However, the absence of local women in Edinburgh can also be interpreted as indicating that shame at an illegitimate pregnancy, and a desire for secrecy from the woman's family, encouraged women to find a haven in which to deliver and recover at a distance from their home. Equally, taken with the high proportion of domestic servants who were inmates of the homes, one can suggest that feelings of guilt, self-

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[149] RGS, *1891 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 75. No babies were recorded.
[150] McCalman, *Sex and Suffering,* p. 16.

interest,[151] or charity in the girl's erstwhile employers, led to them organising their stay in such a home.

Table 3.16 shows some obstetric details of the single patients, divided according to their place of birth, and current residence, with 'mother and baby' homes a separate category.

Table 3.16
Obstetric Circumstances of Single Indoor Patients at the ERMH, in Number of Patients, 1890

	Born Outside Edinburgh (122)	Born in Edinburgh Area (77)	Resident Outwith Edinburgh (18)	Resident in Edinburgh Area (161)	Resident in 'Mother and Baby' Home (33)
Number of Deliveries Recorded	118	75	18	152	33
Number of Babies Born	122	75	18	155	34
Abortions	4	2	0	6	0
Perinatal Deaths	14	8	1	19	4
Maternal Deaths	1	0	0	1	0
Primiparae	86	53	9	111	24
Grand Multiparae	1	0	0	1	0
Labour Classified as Normal and Problem-free	75	56	13	110	23
Maternal Cause for Anxiety	3	3	0	7	0
Intervention in Labour/ Delivery	24	16	2	32	8
Recorded Use of Chloroform	2	3	0	4	1
Recorded Maternal Ill Health	1	1	2	5	0
Serious Delivery Problem	0	2	0	3	0

Source: ERMH Indoor Casebook, Special and Ordinary Casebook, 1890

There is surprisingly little difference between the categories. Those born outwith Edinburgh had a slightly higher proportion of perinatal deaths and of primiparae than those born within the city. They also had a smaller number of normal deliveries. On the other hand, those born in Edinburgh had proportionately more cause to be anxious (3.9% as opposed to 2.5%), were more likely to have a serious problem at

[151] It was apparently claimed that women with a child to support made better servants. (Horn, *The Rise and Fall of the Victorian Servant,* p. 155).

delivery, to be delivered by forceps, and to be given chloroform. As with the married women of this period, this may indicate an increasing local awareness that the hospital was a source of obstetric help as well as shelter.

Slightly more variation can be seen when single patients are divided according to their current residence. Those resident outwith the city had a much lower perinatal mortality rate (5.6%, in contrast to 12% in Edinburgh residents and 10% in home inmates), but overall they were only a small number (18), and only half of them were primiparae, a parous labour often being kinder to the baby. Nonetheless, two women in this group were unwell. Jane Purvis was admitted from Inveresk Poorhouse with a left-sided paralysis, presumably of long-standing,[152] whilst Janet Hunter developed peritonitis after a long labour. Both she and her son were ultimately discharged well.[153] None of this group were given chloroform, which is undoubtedly compatible with the low rate of intervention (11.1%), and the absence of serious delivery or pregnancy-associated health problems, but may also indicate a greater stoicism and lack of expectation among non-Edinburgh residents.

Those resident in the Edinburgh area create a picture of greater maternal ill-health among single mothers, suggesting that this was possibly a factor in their use of the hospital. Not only did one in eight of their babies die around birth, but five of their number were described as ill, three with venereal disease, one of whom died of gonorrhoeal peritonitis 10 days after delivery.[154] The group also includes the only single patients with cause for anxiety. These included not only prematurity and haemorrhage, but also a girl with a deformed spine, who had earlier been hospitalised for nine months.[155] The only single women to encounter serious delivery problems were not only in this category, but also born in Edinburgh. For example, Georgina Pettigrew suffered a ruptured uterus as a result of a transverse lie.[156] Unsurprisingly, more members of this group used chloroform than did any other category. However,

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[152] 1890 ICB, case 38 DBH [038/12bh/90fi].
[153] 1890 ICB, case 29 DBH [029/3bh/90fi].
[154] 1890 ICB, case 53 DBH [079/53bh/90fi].
[155] 1890 ICB, case 32 ARS2 [121/32ss/90si]; 1890 SOCB, facing p. 100.
[156] 1890 ICB, case 38 CEU [144/38u/90fi].

the intervention rate of 20.3%, whilst higher than for single mothers not living in Edinburgh, was similar to that for married mothers resident in the city (20%).

Finally, in 1890 33 patients, mainly from outwith Edinburgh, were resident in 'mother and baby' homes. They were little different from the other groups. Like those not resident in Edinburgh, they had no apparent cause for anxiety, or serious delivery problems. Like those resident in Edinburgh, the great majority were having their first child, and again like them, approximately one in eight of their babies died. Where they did differ was in the intervention rate: 26.7% of 'mother and baby' home inmates were delivered by forceps, compared with approximately 20% in both single and married Edinburgh residents. It could be suggested that this is the result of the higher proportion of women having their first baby in the homes, but at 72.7% this was not greatly different from the 70.3% of Edinburgh residents who were primiparous, but not resident in a home. It can also be suggested that the house surgeons took advantage of the lack of support of these women to practise their instrumental skills. Nonetheless, with the exception of two cases where the fetal head became impacted at the pelvic brim, and ceased to advance, all forceps deliveries among 'home' residents were preceded by a second stage in excess of four hours. Chloroform use was recorded once, in one of the 'impacted' cases.[157]

It is unfortunate that there are few references at this time in the hospital records to the presence of 'mother and baby' homes, as they suggest a possible approaching change in the perception of the ERMH, equivalent to the increase in married women seeking obstetric help. In 1880 John Halliday Croom had described the actual principal function of the hospital as being the provision of 'shelter until the confinement is over' among 'cases ... [who] come voluntarily', with 'serious operative cases sent [only] occasionally'.[158] Little in the 1890 data suggests that there had been a great change in this in the previous ten years, a view supported by the admission, in March 1890, of Mary Anne Brunton, 'owing to her being penniless &

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[157] 1890 ICB, case 26 ARS2 [115/26ss/90si].
[158] John Halliday Croom, 'The Systematic Use of Antiseptics in Midwifery Practice', *Edinburgh Medical Journal,* XXVI No. VIII, February 1881, p. 714.

having no friends'.[159] Nonetheless, the existence of the homes does suggest that the social, sheltering function of the ERMH was beginning to be met by subsidiary institutions. Equally, the homes' use of the ERMH suggests a change in the attitude to childbirth itself, carrying the implication that birth was viewed by the home-owners and clients as a medical event, to be attended by appropriate personnel. However, their provision of Indoor cases to a teaching hospital, always in need of material, implies a less attractive relationship. The existence of the homes also says more about childbirth than just that their need for medical personnel to deliver, and the ERMH's need for cases, could be met by a mutual agreement. The implication of shame, if not secrecy, associated with them also suggests a change in the general attitude to illegitimate birth in contrast to that implied by Stark in 1861. This theme will be examined further in relation to the 1912 data.

3.4.4 1912

In 1912, 300 single women attended the ERMH as in-patients. Table 3.17 shows their social circumstances by place of birth. However, it should be noted that, in contrast to 1890, patients' future addresses were no longer recorded, possibly giving an inaccurate figure for those with no Edinburgh connection.[160] As in previous years, the majority of single patients were born outwith the city: 137 came from elsewhere in Scotland, nine from Ireland, 24 from England, and one from Christiansand, in Norway.

In both groups, there was a decline in women still living in their home area, in contrast to 1890. Of those born outwith the city, 2.9% still lived in their home area in 1912, compared with 4.9% in 1890. In Edinburgh, the figures are 67.5% in 1912, as opposed to 83.1% in 1890. This implies greater female mobility, presumably in search of work, and, with regard to childbirth, it indicates a loss of social support. In 1912 fewer women were domestic servants. Excluding four waitresses and a barmaid, 60.2% of those born outside Edinburgh were in domestic service, compared with 71.3% in 1890. Again excluding four waitresses, 25.6% of women born in the

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[159] 1890 ICB, case 46 DBH [072/46bh/90fi].

city were servants, compared with 48% in 1890. The occupations that replaced service for both groups included office work, a wide range of industrial processes, and daily domestic work. Ten of those born outwith the city were agricultural workers (six skilled), in contrast to none in 1890. Regarding the decline in domestic servants, it appears that the patients of the ERMH in 1912 are mirroring the general decline in domestic service from 1900 onwards, described by Horn.[161] However, the new appearance of farmworkers suggests either less familial tolerance of illegitimacy (that is, that the later legitimising marriages described by Smout and Blaikie had become unacceptable), or that a greater premium was placed on the medical care obtainable through the ERMH. Despite the decline in domestic service, there was a percentage increase in servants from outwith Edinburgh using a 'mother and baby' home: in 1912 19.3% did so, compared with 13.1% in 1890. Again, this may reflect changing attitudes to illegitimacy. This was not matched among Edinburgh natives, when only 3.4% were servants using the homes, compared with 6.5% 22 years before.

Table 3.17
Social Circumstances of Single Indoor Patients at the ERMH, in Terms of Their Place of Birth, in Number of Patients, 1912

	Born Outside Edinburgh [a] (171)	Born in Edinburgh area (117)
Born in Edinburgh	0	117
Born outwith Edinburgh	171	0
Living in home area	5	79
Poorhouse	1	0
No recorded Edinburgh connection	21	0
Described as Domestic servant	103	30
Resident in 'Mother and Baby Home'	52	16
Domestic Servant and from 'Mother and Baby Home'	33	4

Source: ERMH Births Register, 1912

[a] The birthplaces of 12 single women were either not recorded or not known.

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[160] In 1890, 10 patients of 16 who were born and lived outside Edinburgh gave a discharge address in the Edinburgh area.

[161] Horn, *The Rise and Fall of the Victorian Servant*, pp. 171-4.

As in 1890, the single patients of 1912 have also been grouped and examined according to their current place of residence (Table 3.18).

Table 3.18
Social Circumstances of Single Indoor Patients at the ERMH, in Terms of Their Current Place of Residence, in Number of Patients, 1912

	Resident outwith Edinburgh [α] (25)	Resident in Edinburgh area, not 'Mother and Baby' Home (192)	Resident in 'Mother and Baby' Home [β] (74)
Born in Edinburgh	3	97	16
Born outwith Edinburgh	22	95	52
Living in Home Area	5	80	16
Poorhouse	1	0	0
No Recorded Edinburgh Connection	22	0	0
Described as Domestic Servant	10	86	41

Source: ERMH Births Register, 1912

[α] The current residences of four single women are not known, unfortunately including two with same address, seven months apart.

[β] The birthplaces of six Home residents were not recorded.

As in previous years, it can be seen that the great majority of single women lived in the Edinburgh area, and this is even more true when the 'mother and baby' home residents are included. However, a sixth of all the single patients lived outside the city, most of these having no Edinburgh connection, although few were still in the area of their birth. For the first time among single women, three former city residents were returning to deliver in the hospital, a possible indicator of an improving reputation. Only 40% were domestic servants, in contrast to 1890, when 83.3% were. Six others were farmworkers, and three worked in factories. Maggie B, formerly a servant, was an inmate of Inveresk Combination Poorhouse.[162]

Approximately half of those resident in the Edinburgh area were born there, the majority of these still being in their home area. In contrast to 1890, only 44.8% were in domestic service, with another large group (60, or 31.3%) working in manufacturing or shops. Six were engaged in office work, but 17 (8.9%) were

[162] 1912 ICB, case 149 JWB [465/149/bal/1912i].

described by the hospital as 'at home'.[163] In 1912 the great majority of these women (15) were having their first baby, whilst six were not born in Edinburgh. Overall, they appear to be the equivalent of the social admissions for privacy of 1850 and 1870. Indeed, one of their number, Bella O, born and brought up in Edinburgh, was described as being an 'early admission for secrecy'.[164] In 1890 the nearest occupational equivalent had been described by the hospital as of 'no occupation'.[165] However, from their details they appear to be a slightly different group. Overall, 16, or 7.7% of all single admissions, were described as such, but, in contrast to 1912, approximately half of the women were parous, whilst two came from the House of Refuge or similar, and only one from the Cathcart Place home. Ten were Edinburgh natives.

Those Edinburgh residents described as 'at home' in 1912, if they were attempting to conceal their condition, differed by definition from the single girls admitted from the 'mother and baby' homes, whose current residence revealed their problem. In 1912, 25.9% of single women were admitted from 'mother and baby' homes, a large increase on the 16.4% of 1890. The decline in domestic service was seen here too. Slightly more than half (52.7%) were described as domestic servants, compared with 61.4% in 1890, whilst nine worked in manufacturing, eight were shop girls, and eight were 'at home'. The majority of inmates were not Edinburgh-born, and these were most likely to be servants (37), with ten in manufacturing or shop work. Only three born outside Edinburgh were 'at home', compared with five natives. Again, the careers of most inmates of the homes suggest that having come to Edinburgh to work, and becoming pregnant, they were concealing their condition from their families outside Edinburgh.

By 1912 the homes themselves had changed from 1890, and some, at least, had a direct association with the ERMH. In the 1907 Annual Report it was recorded that

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[163] 1881 census Class VI, order 24, sub-order 0.
[164] The entry continues 'Caesarian not wished for (Live child not desirable).' (1912 ICB, case 20 AHFB [164/020/barb/1912i]; 1912 SOCB pp. 128-9).
[165] Also Class VI, order 24, but sub-order 1.

> The Lauriston Home, 118 Lauriston Place, opposite the Hospital (formerly known as St. Luke's Home, Graham Street), is proving a most valuable adjunct to the Hospital. Unmarried girls are received there, both before and after their confinement, at a charge of 5s. weekly. Only those about to become mothers for the first time, and of otherwise good character, are admitted.[166]

However, both addresses occur in the 1912 Births Registers, and also that of the Salvation Army Home in the Vennel. The homes had evidently become much larger. The Lauriston Home took 44 patients during 1912, all but two primiparous. Graham Street, also known as 'Miss Deer's Home',[167] took 21, of whom a third were parous. The Salvation Army Home took in nine, of whom, again, a third were parous. Domestic servants appeared in every home, although they predominated in the Vennel, being seven of the nine inmates there. However, those 'at home' favoured the Lauriston Home. Following delivery, the Lauriston Home, at least, 'endeavour[ed] to assist [the inmates] to get respectable employment to maintain themselves and their infants'.[168] The expansion of the 'mother and baby' homes which occurred alongside pre-existing use of the ERMH as a social shelter for single women wishing to deliver with some privacy, indicates changes both in the hospital, which can be seen to be delegating some of its former social care role to the homes, and in the attitude of the public to childbirth, which was increasingly being seen as an event needing medical attendance.

The obstetric histories of the single patients have also been examined, firstly in relation to their place of birth (Table 3.19). As in previous years, the majority of single women were born outside Edinburgh. There was a marked difference between them and the women born in the city in terms of perinatal and maternal deaths. In 1912 the perinatal death rate for women born outside Edinburgh was 10.5%, a slight improvement on the same group in 1890 (11.5%), and very different to that among Edinburgh natives in 1912 (17.9%). However, this in turn was not as high as that recorded for married Edinburgh natives, indicating that they were more likely to attend for medical reasons. There was also a difference between single women born

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[166] ARERMH for 1907.
[167] 1912 ICB, case 143 FWNH [143/143/hault/1912i].
[168] ARERMH for 1907.

within and outwith the city in 1912 in maternal deaths. In each group one woman died undelivered: one was an out-worker who collapsed in early pregnancy with a cerebral tumour,[169] whilst the other died of eclampsia.[170] However, 1.8% of those born outwith Edinburgh died following delivery, compared with 3.4% of natives. This also compares unfavourably with the married natives, of whom 2.6% died. Eclampsia was the sole cause of death in single Edinburgh-born women, and also accounted for one of the three non-native deaths. Possibly associated with the high number of eclampsia cases, both groups had a high percentage of primiparae, 71.3% in non-natives, and 77.8% in natives.

Table 3.19
Obstetric Circumstances of Single Indoor Patients at the ERMH, in Terms of Their Place of Birth, in Number of Patients, 1912

	Born Outside Edinburgh (171)	Born in Edinburgh area (117)
Number of deliveries recorded	167	116
Number of babies born	171	117
Abortions	4	1
Perinatal deaths	18	21
Maternal Deaths	3	4
Died Undelivered	1	1
Primiparae	122	91
Grand Multiparae	0	0
Labour classified as Normal and Problem-free	124	56
Maternal Cause for Anxiety	7	8
Intervention in Labour/Delivery	22	20
Recorded Use of Chloroform	4	3
Recorded Maternal Ill health	2	3
Serious Delivery Problem	1	6
Referred by outside doctor/ Emergency admission	6	6

Source: ERMH Indoor Casebook, Special and Ordinary Casebook, 1912

The implication that these Edinburgh-born single women were less physically able to cope with labour is also supported by the detail of their ante-natal and labour experiences. Fewer than half their labours (47.9%) were classified as normal and without problems, compared with 72.5% problem-free labours in the non-native

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[169] 1912 ICB, case 47 JHC [515/047/hc/1912i].
[170] 1912 ICB, case 139 JWB [455/139/bal/1912i].

group. Unsurprisingly, they also had a higher intervention rate (17.1% compared with 12.9%), and a higher rate of serious delivery problems (5.1% compared with 0.6%). As a group they more closely resemble the Edinburgh-born married patients of the time (see Table 3.10), than they do single women born outside Edinburgh. One can suggest that like the married women, the single Edinburgh natives were learning that the ERMH was a source of medical help as well as shelter, were increasingly subject to admission on medical advice (five of the six referred women were originally dispensary patients), but, in contrast to those originally from outwith the city, were less physically strong.

The obstetric circumstances of single patients at the ERMH have also been examined according to their present residence (Table 3.20).

Table 3.20
Obstetric Circumstances of Single Indoor Patients at the ERMH, in Terms of Their Current Residence, in Number of Patients, 1912

	Resident outwith Edinburgh (25)	Resident in Edinburgh area (187)	Resident in 'Mother and Baby' Home (74)
Number of Deliveries Recorded	24	181	74
Number of Babies Born	24	184	75
Abortions	0	6	0
Perinatal Deaths	2	30	8
Maternal Deaths	1	6	0
Died Undelivered	1	0	1
Primiparae	20	129	62
Grand Multiparae	0	0	0
Labour classified as Normal and Problem-free	18	77	57
Maternal Cause for Anxiety	2	8	3
Intervention in Labour/Delivery	4	28	13
Recorded Use of Chloroform	1	5	2
Recorded Maternal Ill health	1	4	2
Serious Delivery Problem	0	5	1
Referred by Outside Doctor/ Emergency District Admission	3	7	2

Source: ERMH Indoor Casebook, Special and Ordinary Casebook, 1912

Single women still resident outwith Edinburgh were only a sixth of all single patients. As a group, they contained the highest proportion of primiparae, of whom half were domestic servants. The also had the highest proportion of normal, problem-free births (72%), and the lowest perinatal mortality rate (8%). Nonetheless, there were two deaths, one undelivered, from a cerebral tumour. The account of the other death casts some light on the perception of the ERMH in this group. Jessie R, 19 years old, came from Haddington, although 'in service away from home .... She kept her condition secret from all except her mother and when time came [sic] it was decided that she should come to Maternity Hospital.' On admission she was 'highly nervous and excited, having strong regular pains ... declared she thought she was going to die and was with much difficulty pacified'. She began to fit in the second stage, and despite active treatment continued to do so, dying from apparent heart failure about 16 hours after delivery.[171] She and her mother evidently saw the ERMH as providing a private place away from home for her to deliver secretly, rather than a source of medical treatment. Similarly, Agnes U of Burnhouse, admitted after delivery and treatment for eclampsia by her local doctor, was a '[s]ervant in Bloomiehall, Juniper Green ... [and was] perfectly well during pregnancy which she concealed, doing hard work well'.[172] In this story it is the concealment that is important: it is not clear that her original plans for delivery involved the ERMH. These accounts, and the health of the non-resident patients, both suggest that this group continued to see the ERMH as a place for private delivery away from their home area, rather than a source of medical help.

Those single women resident in Edinburgh, but not in a 'mother and baby' home, clearly differed from those resident outwith the city. They had a high perinatal mortality rate (16%), a smaller proportion of primiparae (69%), and numerically, a larger number of maternal deaths, anxious, and sick mothers. Unsurprisingly, they also had a low rate of problem-free deliveries (41.2%), although their intervention rate of 15% was similar to that of non-residents (16%). However, compared to the other residence categories, this group had a large number of serious delivery

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[171] 1912 ICB, case 2 AHFB [146/002/barb/1912i]; 1912 SOCB pp. 115-18.
[172] 1912 ICB, case 17 AHFB [161/017/barb/1912i]; 1912 SOCB pp. 126-7.

problems, including two craniotomies, a caesarean section, and a post-mortem breech extraction. This group also contained four of the six women whose desire for secrecy has been recorded. Bella O was admitted early 'for secrecy',[173] whilst Jane O 'delivered herself [in her mother's house] .... No one was present & the placenta was also delivered when no one was present. [She] was illegitimately pregnant and was full term.' How she came to the notice of the Leith dispensary is not recorded, but she died from 'TB meningitis' 12 hours after admission.[174] Both Jessie R and Ethel H seem to have been more concerned to hide their condition from their employer and, in Jessie's case, her mother also. Ethel, a servant, was admitted from Lygon Road after delivery,[175] whilst Jessie's 'mistress (Mrs Dow) said [on 19 January] that pat. had been confined to bed since 15. Jan with a bilious attack! & pains in abdomen. ... Mrs Dow her mistress did not suspect pat[ient] was pregnant .... Pat[ient] went home at New Year time on a visit to her mother at Kinghorn, who never suspected that she was pregnant. Pat[ient] asked her mother to buy her a pr. of No.19 Corsets (wh. the matron alleges are small even for a non-pregnant woman?!)'[176] Thus the single women who lived in Edinburgh and used the ERMH appear to illustrate two aspects of the hospital's work. Some came because of ill-health or anxiety, or because their admission was arranged by another medical agency, but some continued to use it as a place of social shelter.

The final group of residents are the inhabitants of the three 'mother and baby' homes. In comparison to the other Edinburgh residents, they seem very healthy. Most were primiparae (83.8%), but despite this, most had problem-free deliveries (77%), although one eclamptic died undelivered, and one was induced 'on account of great contraction of pelvic inlet'.[177] Their perinatal mortality rate was, at 10.8%, appreciably lower than that of other Edinburgh residents in the hospital, married or single, although not as low as that of single women living outside the city, nor of Outdoor patients. Eclampsia was the sole reason for anxiety. However, they did have some health problems. One patient was suffering from erysipelas at delivery, whilst

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[173] 1912 ICB, case 20 AHFB [164/020/barb/1912i]; 1912 SOCB pp. 128-9.
[174] 1912 ICB, case 122 JHC [590/122/hc/1912I]; 1912 SOCB pp. 248-50.
[175] 1912 ICB, case 36 AHFB [180/036/barb/1912i].
[176] 1912 ICB, case 24 FWNH [24/024/hault/1912i]; 1912 SOCB pp. 8-10.

another was described as having gonorrhoeal rheumatism on discharge. According to Anne Oakley, Haig Ferguson based his 1915 support for antenatal out-patient clinics and visits, on his experiences with the Lauriston Prematernity Home at 4 Lauriston Place, where mothers were admitted two months before delivery, were well-rested and well-fed, and had improved outcomes in labour and delivery.[178] One can certainly suggest that the Home inmates of 1912 benefited from their stay in comparison to Edinburgh residents who did not use the Homes, at least in terms of childbirth, but those who lived outside Edinburgh seem to have fared as well.

Interpreting the motives of the single women who attended the ERMH is more difficult than understanding the reasons that drove married women to the hospital. Despite the apparently relaxed attitude of very poor Scots to marriage and illegitimacy, in every year studied a small number of patients can be identified who appear to have come to the ERMH to maintain secrecy about their condition in their own neighbourhood. The difference by 1912 is that this motive could be spoken about, at least to the house surgeon, and therefore recorded. However, for the majority of single patients, as with married women for much of the period studied, the hospital offered principally a social shelter at the time of delivery. By 1912 this aspect of the hospital's work was increasingly being met by the 'mother and baby' homes, whilst the hospital provided technical care at delivery. As with married patients, single patients were increasingly aware that the hospital could provide medical as well as social care, and this was more acceptable to them. However, consideration must also be given to increased persistence or authority on the part of the doctors or nurses who persuaded single women to be admitted, and possibly the patient's lack of family support at that time.

3.5 Attitudes of Patients to the Hospital

Ultimately use of the hospital was a matter of choice, as shown by the continuing presence of girls with concealed pregnancies admitted as emergency cases in 1912. However, to seek admission was not always an appealing decision. Casebooks are

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[177] 1912 ICB, case 106 FWNH [106/106/hault/1912i]; 1912 SOCB pp. 75-7.

not necessarily the best source for evidence of patient opinion and attitudes, but nonetheless they include some instances where patients appear to give their judgement of the hospital and its treatment. Whilst numbers of in-patients using the ERMH increased steadily after 1875, a small number of incidents suggest that they were not always happy or grateful at the treatment they received. This dissatisfaction appears to increase towards the end of the period studied. In 1871 Elizabeth Neilson '[l]eft the Hospital before confinement', apparently in protest at the invasion of privacy resulting from Matthews Duncan's new regime of daily abdominal palpation and auscultation.[179] In 1912, Jeanie W 'left R.M.H. 2 hrs after delivery - Refused to allow her Hair to be cleaned - crawling with vermin.'[180] Both women reacted to objectionable treatment by leaving. It is also possible to interpret Jessie R's concealed pregnancy, described above, as a rejection of the ERMH and its treatment, rather than an attempt to hide her circumstances from her mistress. Six years previously, she had been delivered by craniotomy in the hospital. On the second occasion, in 1912, she preferred to labour alone until her employer was so worried by her illness that she summoned a doctor. By this time 'the head of the child [was] well down on the perineum & the pat. very septic ....[in] profound shock'. She had already suffered a uterine rupture, and the baby was not only dead but decomposing on delivery.[181] Emily G, a single girl and presumably an associate dispensary patient, also rejected medical advice. She had been in the Infirmary earlier in her pregnancy, suffering from jaundice and albuminuria and had been 'discharged with injunctions to carry on her treatment. This she did not do.' Following delivery she began to fit, and died a day later.[182] However, against such examples of rejection of the hospital must be set that of Jane Thomson, who returned to Edinburgh from Stockton-on-Tees in 1890, specifically for ERMH care, and the women of 1912 who had come to the hospital, like Mrs K of Pilrig, 'in order to have a live child if it is possible'.[183]

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[178] Anne Oakley *The Captured Womb: A History of the Medical Care of Pregnant Women* (Oxford: Basil Blackwell Publisher Ltd., 1984), pp. 50-3.
[179] 1871 SOCB, p. 122.
[180] 1912 ICB, case 102 FWNH[102/102/hault/1912i].
[181] 1912 ICB, case 24 FWNH [24/024/hault/1912i]; 1912 SOCB pp. 8-10.
[182] 1912 ICB, case 24 AHFB [168/024/barb/1912i]; 1912 SOCB pp. 131-2. On admission, she was described as 'Recommended: District Student'.
[183] 1912 SOCB pp. 84-6.

3.6 Conclusions

Hospital delivery in Edinburgh has now been almost universal for at least the last 30 years, and therefore women's personal motives in selecting hospital care are lost in the general medical and social pressure to conform. However, to choose hospital care was so unusual in the nineteenth century that individual motives can be looked for. The examination of patient data in this chapter suggests that those motives changed over the period studied, indicating a change in patients' understanding of the purpose of a maternity hospital. The general patient data shows that until the fourth year studied, 1912, ERMH Indoor patients were not typical of the childbearing population in age or parity, nor of the city or national population in terms of origin, marital status, or occupation. Outdoor patients were more representative, but, by being delivered at home, were also behaving in a more conventional manner. Examination of subdivisions of the patients, and their individual histories, show that this atypical nature arose from their using the hospital for social reasons rather than as a source of medical treatment. The data suggest that the ERMH succeeded in throwing off its previous principal image as a shelter for destitute parturient women only in the early twentieth century, if then.

However, the patient data also suggest a change in attitude towards childbirth among the poor. By 1912 the approximately 30% of the population of Edinburgh who were attended by ERMH or associate dispensary staff had in effect abandoned the practice of delivery by relations or an untrained midwife (although these may still have been present in the puerperium), in favour of a medicalised childbirth administered by trained professionals or their pupils. With this went increased acceptance of the need for in-patient care in the event of ill-health or delivery problems. A similar attitude can be seen in the providers of private 'mother and baby' homes, in which the benefits of professional attendance were increasingly recognised, and where births now took place following transfer to the specialist surroundings of the hospital. In addition, the data suggest the possibility of a decline in the health of the Edinburgh-born poor by 1912, which may have significance for the developing medical attitude to childbirth. Incidentally, the data also indicate changes in the social life of the

extreme poor, in regard to apparently changing attitudes to marriage, and to illegitimacy.

This chapter has shown that until the early twentieth-century, most users of the hospital were seeking social shelter rather than any medical intervention, and this in turn has repercussions for other aspects of the hospital's work, the treatment given to patients, and especially, its educational role. Chapter 4 will discuss the change to more active treatment at the hospital: whilst this was partly due to obstetricians' increasing confidence, it must also have resulted from the growing number of complex cases being admitted. This in turn created difficulties for the management, which was faced with explaining to a subscribing public the resultant increasing maternal mortality. Equally, in earlier years, the presence of so many impoverished but otherwise well patients diminished the variety of experience that could be offered to the many hospital trainees, male and female, when inside the hospital. Outdoors, by 1912 the focus of pupil midwives on healthy parous deliveries gave them a different attitude to birth to that of the house surgeons, who saw many more complex and fatal cases.

This chapter has shown that the development of a maternity care institution is not only a matter for the associated professionals, but that the role of its patients is also crucial. They shape the institution by their understanding of its purpose and their response to that understanding. This chapter has also demonstrated changing attitudes to childbirth in both the hospital Indoor and Outdoor population, in that by the early twentieth century birth among the poor was less family-orientated, with greater professional involvement. However, although the casebooks hint strongly at a decline in family and long-established neighbourhood support as a reason for this, overall they are a poorer source for this motivation, as it relies on broad assumptions about rural life and the effects of immigration that cannot be substantiated from casebook data. This chapter has also illustrated the changes in maternity care and its increasing medicalisation, through patients' histories. These show the increasing acceptance of greater medical care at delivery, and the recognition of its benefits by the patients, but acknowledges that in this area the casebooks provide a series of

sometimes-conflicting individual attitudes. However, when changes in maternity care, particularly increasing medicalisation, are the result of changes in treatment, especially the introduction of antisepsis and the imposition of middle-class ideas of rest in the puerperium, they are discussed in the next chapter.

Chapter 4

Treatment and Diagnosis: The Management of Childbirth and Associated Problems at the Edinburgh Royal Maternity Hospital 1844-1914

4.1 Introduction

This chapter examines the treatment given to women who attended the Edinburgh Royal Maternity Hospital [ERMH] as either in- or out-patients, between the years 1844 and 1914. Treatment is more than a range of objective solutions to a series of technical problems: embedded within it may be a number of un-expressed social attitudes, principally to do with perceived social status. The ERMH material offers an opportunity to examine the actual treatment of patients, both in technical and social terms, at a time of innovation and apparent change in childbirth. There are a large number of records extant, and it is possible to link patients' medical and social histories on an individual basis.

Historical examinations of the treatment of maternity patients have taken different forms. Writing in the 1950s, J. Munro Kerr, an eminent obstetrician, saw treatment only in terms of improving medical knowledge and technology, an attitude continued in Radcliffe's *Milestones in Midwifery*.[1] The passive role of patients implied by this continued in the feminist interpretation of nineteenth–century medical approaches to obstetrics and gynaecology, when the new treatments described in the nineteenth-century medical press, and apparently offered to labouring women, were seen as degrading and invasive.[2] Such a medical focus then fell from favour, to the extent that in 1995 Adrian Wilson could write an appeal for the re-admission of analyses of treatment to historical debate, pointing out that childbirth is both a bodily and a

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[1] J. M. Munro Kerr, R. W. Johnstone, Miles H. Phillips (eds) *Historical Review of British Obstetrics and Gynaecology 1800-1950* (Edinburgh: E. & S. Livingstone Ltd, 1954), pp. 3-40, 71-84; Walter Radcliffe *Milestones in Midwifery* (Bristol: John Wright & Sons, 1967).

social event, and suggesting that eighteenth-century treatment of prolonged labour was not uniform and could provide evidence of the changing ideas of doctors and other practitioners.[3] This chapter seeks to extend Wilson's ideas.

The chapter argues that treatment is far more than the application of expert knowledge to a passive recipient implied by Kerr or the feminists. It represents a form of contract, albeit an unevenly weighted one, between patient and doctor, to which both bring their ideas and prejudices. Analysis of treatment offered and accepted may make these apparent, in addition to exposing the development of more medically-orientated ideas as described by Wilson. Thus, this chapter suggests that the analysis of the treatment given to patients at the ERMH may indicate the increasing medicalisation of childbirth in Edinburgh.

Further, the detailed examination of the treatment given can provide other historical evidence. It can be taken in conjunction with the patient data (as examined in Chapter 3), to illustrate the changing nature of the hospital, and possibly to provide evidence of women's health, both within and outside Edinburgh. It can also be combined with the names and status of individual staff members to indicate changes in the experience and skills of the professionals involved, and thus show the development of the separate maternity care professions.

The ERMH data offer still further possibilities. As discussed by Risse and Warner,[4] they offer the opportunity to examine the actual practice of the hospital, both Indoors and Out, and therefore the degree to which the new treatments of the nineteenth century (particularly anaesthesia and instrumental or surgical delivery) were actually used. Whilst it must be recognised that doctors may have behaved differently in private practice, on the whole this is not borne out by a difference between the

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[2] See, for example, Lois Magner *A History of Medicine* (New York: M. Dekker, 1992), Coral Lansbury 'Gynaecology, Pornography and the Anti-Vivisection Movement', *Victorian Studies*, 28 (1984-5), pp. 413-37.
[3] Adrian Wilson *The Making of Man-Midwifery: Childbirth in England 1660-1770* (London: UCL Press, 1995), p. 6.
[4] Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5 (1992), pp. 183-205.

ERMH material and other studies of birth in the period.[5] Thus the data provide some evidence of the general medical attitude to childbirth in the late nineteenth and early twentieth century.

Using both individual case histories and whole year treatment data, this chapter establishes that a change in approach to intervention at delivery occurred in the late nineteenth century, but that this was not synchronous with the introduction of anaesthesia, as has been suggested by some feminist writers.[6] Nor was it initially the result of an increase in difficult cases attending the ERMH. Instead it appears to have come from an increase in medical professional confidence. By the end of the period, the ability to deliver with instruments can be seen as defining the qualified doctor. This chapter also establishes that an increasing emphasis was placed on rest, medical care and supervision in the puerperium for all cases, and that this escalated following the introduction of routine antisepsis and institutional concern over infection rates. This provided a new and important role for nursing professionals, partly usurping the traditional function of family and friends, and contributing greatly to medicalisation. Nonetheless, the examination of pain relief in this chapter suggests that birth itself continued to be seen as physiological, and endurable by the majority of women. It is also suggested that a small number of patients rejected aspects of their treatment, and that some areas of medical investigation or treatment remained repugnant to them.

This chapter examines the treatment given to the women who attended the ERMH as either in- or out-patients, in the years 1850, 1870, 1890, and 1912, and whose social histories have already been analysed in Chapter 3. It is based principally on analysis of the records of their cases in the Indoor and Outdoor casebooks, although exceptional cases were also recorded in more detail in the Special and Ordinary casebooks. As a result of this, the small proportion of cases that involved

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[5] Judith Walzer Leavitt *Brought to Bed: Child-bearing in America 1750-1950* (New York: Oxford University Press, 1986), pp. 44-60; Patricia Jalland *Women, Marriage and Politics 1860-1914* (Oxford: Clarendon Press, 1986), pt.2, pp.131-185.

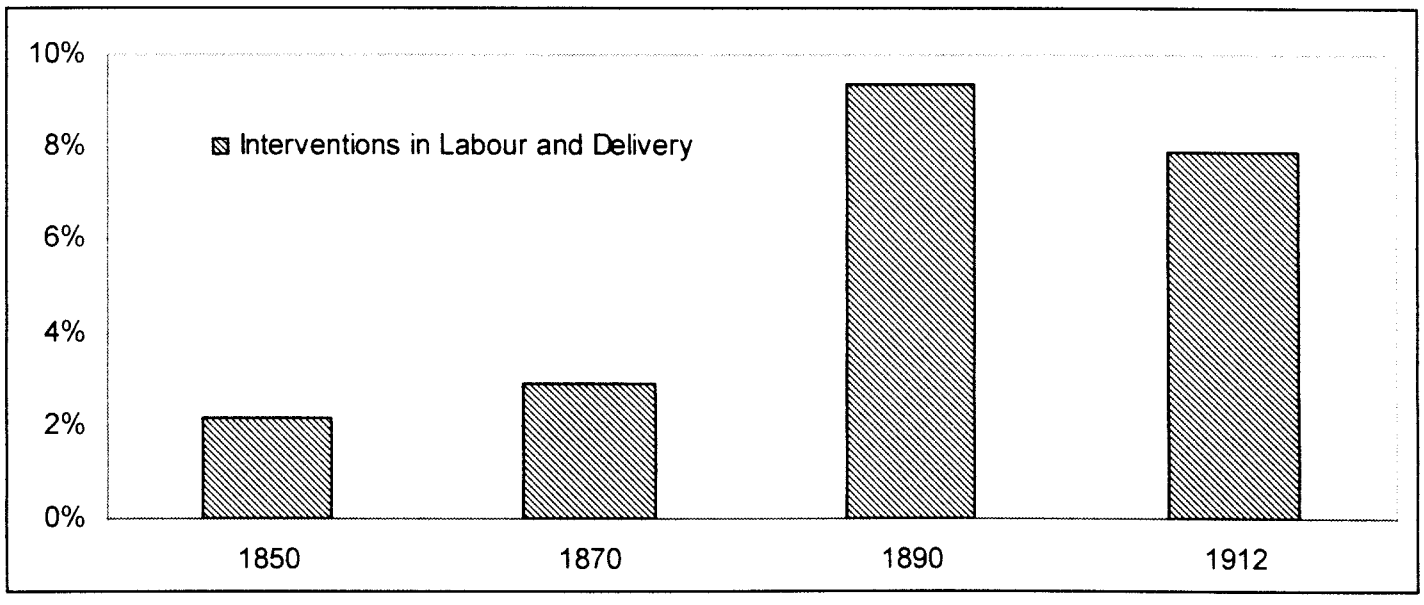
[6] See, for example, Magner *A History of Medicine*, pp. 274-5; Jenny Carter and Thérèse Duriez *With Child: Birth Through the Ages* (Edinburgh: Mainstream, 1986), pp. 118-19. Loudon also notes the time discrepancy. (Irvine Loudon *Death in Childbirth* (Oxford: Clarendon Press, 1992), pp.183-4, 345-6).

intervention at delivery, which are clearly identified in the casebooks by 'remarks' or other additions to the record, are, somewhat perversely, examined in advance of the far greater number who delivered without any recorded interference. In this second group the type of delivery has been inferred, as it has not been recorded directly, and overall there is much less information about their treatment. This attitude to recording the nature of the deliveries suggests a medical focus on the abnormal rather than the normal. Within the two areas of abnormal and normal deliveries, the material is divided by themes and examined chronologically. However, the general data on deliveries at the ERMH, and the increasing trend towards intervention, are examined first.

4.2 Intervention in Labour and Delivery at the ERMH 1850-1912

Throughout the period studied, whilst normal deliveries predominated, the number of patients in the Indoor and Outdoor practice of the ERMH who received medical intervention in labour and delivery (that is, whose labour was accelerated or induced, or who were delivered by either instruments or manipulation of the fetus), increased.

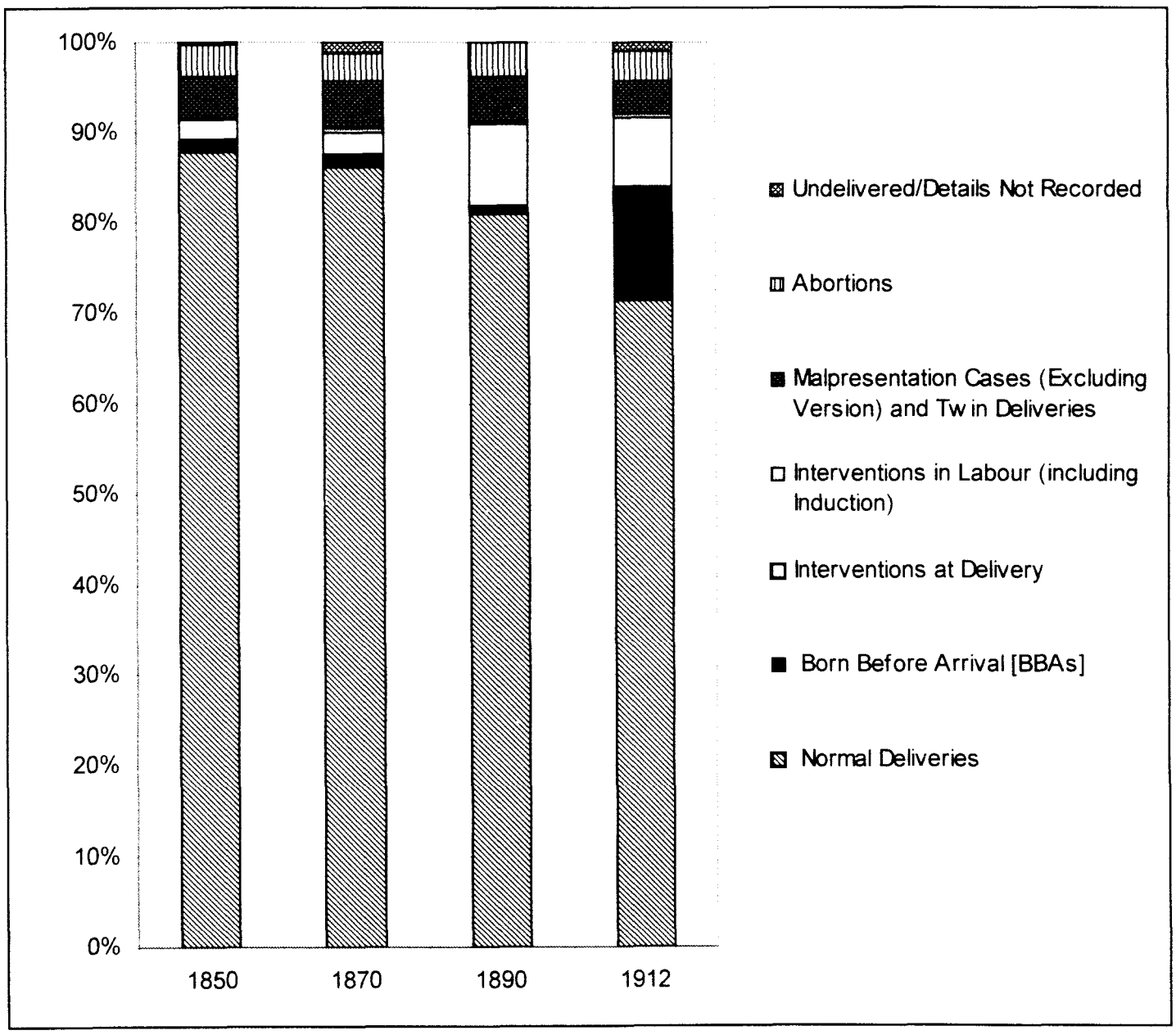
Figure 4.1
Cases of Intervention in Labour and/or Delivery in the Combined Indoor and Outdoor Practice of the ERMH, 1850-1912



Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912.

Figure 4.1 shows that the proportion of intervention cases increased fourfold in singleton cases between 1870 and 1890, from 2% to 9%.[7] Thereafter, there was a small percentage decline in intervention in 1912. Whilst intervention in the first stage of labour, that is acceleration or induction, was practised, it can be seen from Figure 4.2 that the number of cases in which this occurred independently of other intervention was small.

Figure 4.2
The Proportion of Different Types of Case in the Combined Indoor and Outdoor Practice of the ERMH, 1850-1912



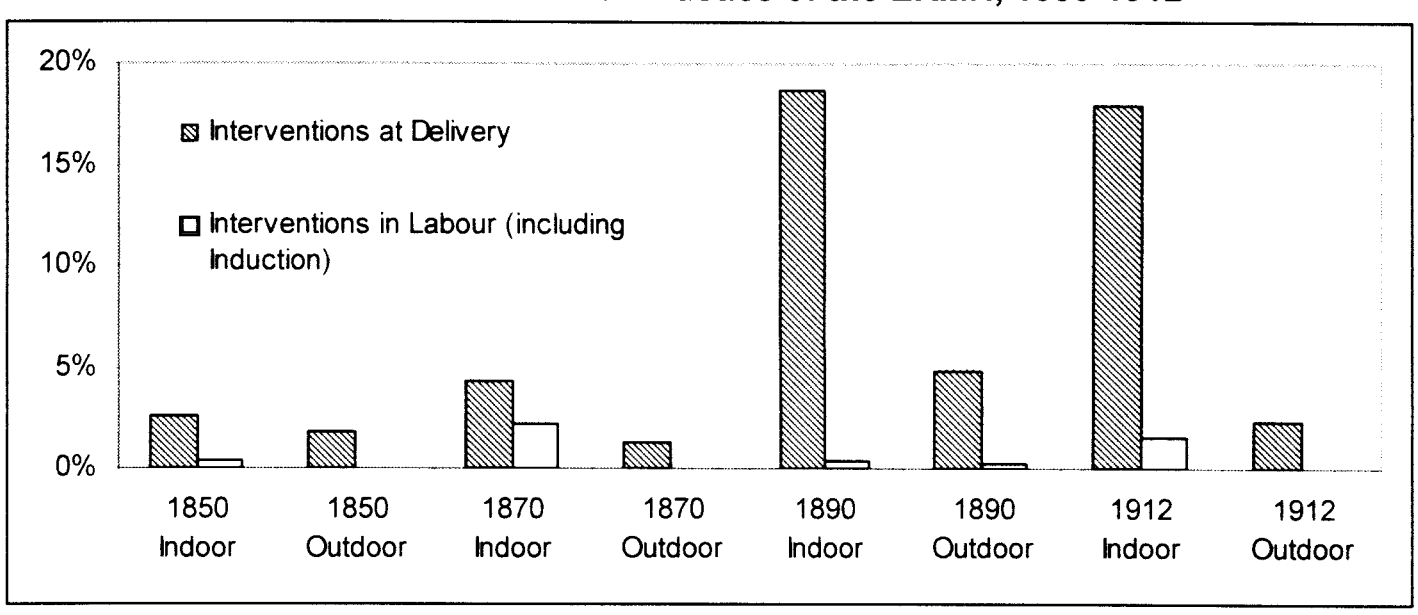
Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912.

This figure also shows that, in 1850 and 1870, approximately 88% of deliveries attended by ERMH staff were normal. In 1890 this declined to 80% and there was a

[7] Malpresentation cases not culminating in intervention, including spontaneous breech deliveries, and

corresponding increase in interventions. However, the apparent decline in normal deliveries attended by the hospital is accentuated in 1912 by the large number of (mainly) district cases when the baby was born before hospital staff arrived, or BBAs. When these are included with the normal deliveries the proportion of such deliveries in 1890 and 1912 is similar.

Figure 4.3
Contrasting Levels of Intervention
in the Indoor and Outdoor Practice of the ERMH, 1850-1912



Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912.

Whilst the overall trend was upward, the increase in intervention was not a simple rise. Figure 4.3 shows that although there was an increase in intervention in the Indoor practice between 1850 and 1870, there was a small decline Outdoors. However, numbers are so small that this is the result of the very exceptional transfer into the hospital, in obstructed labour, of one originally Outdoor case. By 1890 interventions at delivery had increased both Indoors and Outdoors, the latter to the level of 1870 Indoor practice. By 1912, although the actual numbers had more than doubled,[8] there was a small percentage decrease in the number of interventions in the hospital. However, the dispensary policy of transferring into the hospital any case involving more than a simple forceps delivery for delay or minor disproportion, had reduced the level of interventions outwith the hospital to half that of 1890. Thus there

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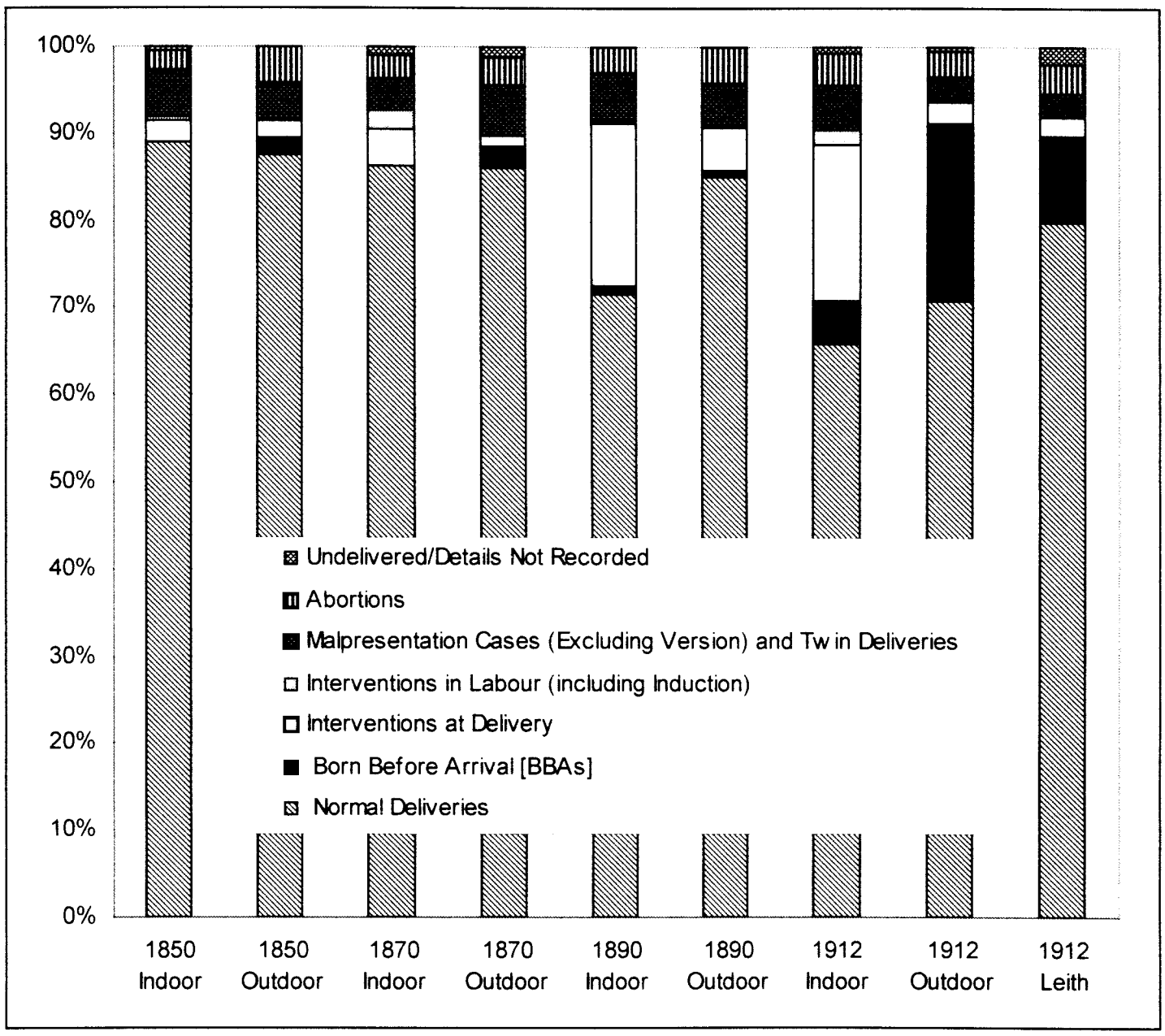
twin deliveries, have been excluded, as have abortions.
[8] In 1890 there were 55 interventions at delivery Indoors; in 1912 there were 113.

was a divergence in Indoor and Outdoor practice after 1870, which can be seen in more detail in Figure 4.4.

Figure 4.4
The Increasing Divergence in Indoor and Outdoor Delivery Practice at the ERMH, 1850-1912



Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912.

The changes in the percentage of cases of intervention at delivery between 1870 and 1890 indicate either an overall change in the medical use of such intervention, or a change in the type of patient using the services of the ERMH. Chapter 3 has shown the latter not to be the case. However, the further changes in Outdoor instrumental deliveries between 1890 and 1912 indicate much greater acceptance of hospital treatment by the patients. The following sections (4.2.1-.3) examine the intervention practice of each year in more detail from the viewpoint of both doctors and patients.

although, given the similarities of 1850 and 1870, these two years are considered together [1850/1870].

4.2.1 Intervention in Labour and Delivery at the ERMH, 1850/1870

In the combined Indoor and Outdoor practice, in these two years only 2-3% of deliveries involved some form of intervention (30 cases).[9] Of these interventions, two-thirds were forceps deliveries (Table 4.1), and these are examined first.[10]

Table 4.1
Number of Forceps Deliveries at the ERMH (Indoor and Outdoor), 1850-1870

	1850 Indoor	1850 Outdoor	1870 Indoor	1870 Outdoor
Forceps Deliveries	5	7	[a] 5	[a] 4
of which:				
Primigravidae	5	6	[a] 5	[a] 4
Laborious Labour Recorded	3	6	2	2
Second Stage of More Than 3 Hours Recorded	3	1	1	0
Maternal Deaths Recorded	1	2	[a] 1	[a] 1
Infant Deaths Recorded	3	4	[a] 2	[a] 1
Delivered by Professor	2	0	1	0
Delivered by Senior Doctor	2	6	3	2
Delivered by Supervised House Surgeon	1	1	1	2
Total Deliveries	270	564	184	404

Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870.

[a] The same case appears in both casebooks.

The circumstances of almost all of the 20 women delivered by forceps in 1850/1870 conform to the contemporary understanding of contracted pelvis,[11] the complication of labour most feared by all concerned, because of the inescapable need for action

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[9] This excludes three twin deliveries in 1870 when in two cases forceps were only applied to the second twin, whilst in the third both were delivered by forceps, but no further details are available. There were no instrumental twin deliveries recorded in 1850. (1870 Outdoor Casebook [OCB], cases 568 and 5288 [034/568/70fo and 090/5288/70so]; 1870 Indoor Casebook [ICB], case 1649 [065/1649/70fi]).

[10] The obstetric forceps were invented by the Chamberlen family in the seventeenth century, became public knowledge in the eighteenth, and were the most successful of the instrumental aids in protracted deliveries. (Audrey Eccles *Obstetrics and Gynaecology in Tudor and Stuart England* (London: Croom Helm, 1982), pp.117-18).

[11] One of the two exceptions to this was Mary McCormack, who had a short forceps delivery of her third child after a prolonged labour in which the head and arm presented together. (1850 OCB, case 3245 [133/3245/50fo]).

and the poor survival rate, particularly when it culminated in obstructed labour.[12] As a group these patients present a clear picture of difficult labour and an obstructed second stage, despite ample time being allowed for spontaneous delivery. With one exception, these patients were delivering their first child, so their pelvic capacity was unknown. The majority of their labours were classified as 'laborious', although actual labour duration is available only for some Indoor cases. The shortest labour recorded totalled 17 hours and 35 minutes, whilst the longest was 58 hours and 40 minutes. Time spent in the second stage of labour ranged from three to ten hours for all the women, as opposed to the norm of two to four hours. [13]

In conformity with the Hospital Rules,[14] 15 of the women were delivered by senior doctors, the remaining five being delivered by a house surgeon under the supervision of his superior. Outcomes were not good: a fifth of the women delivered by forceps died, two from infection, one 'sank the next day at 8p.m. having been delivered the previous day at 4p.m.',[15] whilst no cause was suggested for the other. Almost half of the babies died before or shortly after birth, although this was not evenly divided between the two years studied. In 1850 six of the seven infant deaths were stillbirths. In 1870 all the children were born alive, but two succumbed whilst still in hospital care: Baby Reddington, '[delivered with] Long Forceps - ... lived for about an hour'.[16] Contracted pelvis or obstructed labour was identified by contemporaries as the cause of problems in four, possibly five of the above cases, whilst two in 1870, both attended by Dr Charles Bell as senior, were ascribed to 'inertia', implying muscular rather than bony deficiency. Maternal morbidity as a result of such traumatic labours is hard to assess, as no Indoor forceps delivery cases stayed more than 15 days postnatally in either 1850 or 1870. Outdoors, only Bridget Leonard,

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[12] Research by Loudon suggests that, with the probable exception of Glasgow, the incidence of contracted pelvis in Britain remained fairly constant at one in a thousand deliveries. However, it became an increasingly popular topic in the medical press. (Loudon, *Death in Childbirth*, p.130-43).
[13] Thus, in 1850 Catherine McLairn spent nine-and-a-half hours in the second stage before her forceps delivery by John Landell, the house surgeon, under the supervision of Dr Weir (1850 ICB, case 2205 [115/2205/50si]). There was one exception: in 1850 Helen McManus was delivered of a posterior position baby by Professor Simpson within five minutes of entering the second stage. (1850 ICB, case 1191 [026/1191/50fi]).
[14] *Rules and Bye-Laws of the Edinburgh Maternity Hospital,* (Edinburgh: Andrew Murray, printer, n.d.), 'House Surgeons', paras.3-5, pp. 3-4.
[15] 1850 OCB, case 3558 [125/3558/50so].

delivered in 1850, appeared slow to recover. She was described as having 'paralissis [sic] of bladder since application of forceps', after a slow and ultimately obstructed labour and postpartum haemorrhage.[17]

Table 4.2
Number of Other Interventions at Delivery at the ERMH (Indoor and Outdoor), 1850-1870

	1850 Indoor	1850 Outdoor	1870 Indoor	1870 Outdoor
Manipulative Deliveries	0	4	2	1
Destructive Operations	1	0	1	0
Abdominal Operations	1	0	0	0
of which:				
Patient Parous	2	4	2	1
Maternal Deaths Recorded	1	0	0	0
Infant Deaths Recorded	1	4	3	1
Delivered by Professor	0	0	0	0
Delivered by Senior Doctor	1	2	3	1
Delivered by Supervised House Surgeon	0	1	1	0
Delivered by Unsupervised House Surgeon	1	1	0	0
Total Deliveries	270	564	184	404

Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870.

The remaining third of intervention cases (ten in total) can be seen in Table 4.2. They are a diverse group, with only their multiparity in common. Only one was primigravid, Madeline Henderson, about whom few details are recorded. She was described as being delivered by craniotomy in 1870.[18] The other destructive operation followed on a long parous labour with a face presentation in the hospital in 1850. No details are recorded of this case, except that the decision to perform the craniotomy was made after a second stage of at least two hours, with the implication that with a larger presenting part, the head did not descend.[19] Manipulative delivery by internal podalic version, or 'turning', was employed in six cases which illustrate the principal applications of this mode of delivery as recognised in the seventeenth and eighteenth centuries.[20] Thus four shoulder presentations were delivered this way

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[16] 1870 ICB, case 1758 [061/1758/70si].
[17] 1850 OCB, case 3009 [031/3009/50fo].
[18] 1870 ICB, case 1658 [074/1658/70fi]. For further details of this destructive operation, see Eccles, *Obstetrics and Gynaecology*, pp. 110-13; Loudon, *Death in Childbirth*, p.134.
[19] 1850 ICB, case 2038 [073/2038/50fi].
[20] This was apparently the oldest of the widely used methods of delivery in obstructed labour (Eccles, *Obstetrics and Gynaecology*, pp. 115, 127).

Outdoors in 1850, whilst it was also used to deliver quickly a dispensary case of cord prolapse in 1870. Turning was carried out by a senior doctor in every case except one.

However, within the hospital in 1870, version was used to deliver two patients whose histories appear to be very similar, and who both illustrate the accepted management of known contracted pelvis. Mrs Airey, an engineer's daughter, 28 years old and in her fourth pregnancy, was 'sent up from Penrith to be prematurely delivered in consequence of contracted pelvis'. After 16 days' stay in the hospital 'Dr. Keiller dilated Os artificially turned and extracted', but failed to deliver a live baby.[21] Mrs Stewart, 26, and also in her fourth pregnancy, but with an unknown history, was similarly delivered two days after admission, by a group that included Professor James Simpson. She stayed in the hospital for ten weeks afterwards, presumably recovering.[22]

There was also one abdominal delivery: Katerine Davidson was delivered by caesarean section by Dr George Harley, one of the house surgeons, in 1850.[23] She did not survive, (and may have been already dead), although the baby did: sadly the main account of the case has also perished.[24] Maternal mortality in this group of intervention cases was much lower: Katerine Davidson's was the only death. However, hers was also the only baby to be born and discharged alive. Maternal morbidity is harder to assess. A fuller than usual record shows that Mrs Stewart took 72 days to be discharged; Madeline Henderson was described as 'improveing [sic]' rather than the more usual 'well' when she was discharged.

Surgical induction/acceleration not associated with other interventions in labour was used Indoors on three occasions in the two years 1850 and 1870. In 1850 Annie Campbell Brown's labour was induced in consequence of 'severe flooding'. Both she

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[21] 1870 ICB, case 1615 [031/1615/70fi].
[22] 1870 ICB, case 1599 [015/1599/70fi].
[23] For the rarity of caesarean section in Britain at this period, see Loudon, *Death in Childbirth*, pp. 133-7.
[24] 1850 ICB, case 2037 [072/2037/50fi].

and the baby were discharged well.[25] In 1870 both Helen Skinner and Jessie Rose were suffering strong but irregular pains, an early rupture of membranes, and a well-applied cervix. In both cases the house surgeon dilated the cervix digitally under chloroform, and a successful delivery resulted.[26]

Thus the number of intervention cases in 1850/1870 was very low. In part this reflects the type of patient who attended the hospital, shown in Chapter 3 to be more in search of shelter than medical treatment, but it also indicates the prevailing attitude to treatment, that intervention at delivery should be kept to a minimum. Here the evidence of actual practice contrasts with pro-midwife or feminist writers who believe that forceps were used unnecessarily in the mid-nineteenth century to hasten delivery.[27] Equally, the lack of intervention at the ERMH does not appear to indicate *per se* a lack of concern for poor patients. The ERMH evidence is supported by recent examination of contemporary sources, which suggests that the fear of forceps felt by both mother and friends, kept their use to a minimum for much of the nineteenth century.[28]

The ERMH data also provide evidence of the medical rationale behind intervention, with its low incidence at this period suggesting that the normality of labour was emphasised, and that intervention only occurred when a case could be proven to be abnormal. Doctors undoubtedly expected strong evidence of obstructed labour before they were prepared to intervene. In the case of primigravidae, forceps delivery followed prolonged labour with minimal fetal descent. In the case of parous women known to have pelvic problems, the aim was to save the mother's life: the pregnancy was interrupted and the child delivered by manipulation. The data also illustrate the caution with which doctors approached intervention. Senior doctors were present at almost all intervention cases, and normally delivered them. As will be shown in

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[25] 1850 ICB, case 2155 [065/2155/50si].
[26] 1870 ICB, cases 1753 and 1754 [056/1753/70si and 057/1754/70si]. The technique is described and condemned by Carter and Duriez as the first stage of accouchement forcé, a vogue for which, they believe, followed the introduction of chloroform. (Carter and Duriez, *With Child,* p. 118).
[27] See, for example Donnison, *Midwives and Medical Men,* pp. 41-4, and Wilson, *The Making of Man-Midwifery,* p. 98.
[28] Leavitt, *Brought to Bed,* p. 48; Wilson, *The Making of Man-Midwifery,* p. 100.

Chapter 5, intervention at Indoor deliveries at this time was generally preceded by consultation between senior doctors. Simpson's lectures also show his reluctance to advocate forceps. Instead he advised his students that in an urban practice they should not take forceps with them when called to a case, but send for them if necessary. Otherwise there was 'a great temptation to use them in a tedious labour which we should always if possible avoid'.[29] This cautious attitude can also be seen in the contemporary medical press.[30] To some extent, this caution can be related to poor equipment and lack of experience in its use, but it can also be suggested that some of the reluctance to use forceps originated in the professional association of the ERMH's senior doctors with the College of Physicians. Thus, in the early period of the ERMH, both doctors and patients believed that birth should be allowed to take place unaided if at all possible, and distrusted the means of intervention available. Minimal intervention at delivery took place.

4.2.2 Intervention in Labour and Delivery at the ERMH, 1890

By 1890 the level of intervention at delivery had increased markedly, from approximately 4% to almost 19% Indoors, and from just over 1% to 4.5% Outdoors, (Figure 4.3), although once again this was not the result of any increase in inductions independent of other interventions. In contrast to 1850/1870, when two-thirds of intervention cases had been delivered by forceps, such deliveries now comprised approximately 85% of all interventions, whilst manipulative and abdominal deliveries had declined to approximately 15%. There were no destructive operations in 1890. Closer examination of the 76 singleton forceps deliveries illustrates the changes that had taken place.[31]

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[29] Mackay, Heads of Lectures, Vol.1, p. 134. Possibly he was being ironic.

[30] '[T]he pressure of forceps on the fetal head, in the case of a narrow pelvic brim, is dangerous, and is an argument in favour of turning', (Alexander Keiller, *Edinburgh Medical Journal [EMJ]*, XIV, 1869, p. 760); '[T]he forceps ... present a very formidable appearance ... frequently objected to by both patients and friends ...', (Mr. Charles Amsden, *EMJ*, XV (1869), pp. 81-2); a review of Robert Barnes' *Lectures on Obstetric Operations ... a Guide to the Management of Difficult Labour*, implied forceps were being applied both too late, and incompetently.(*British Medical Journal [BMJ]*, I, 1870, pp. 312-13).

[31] There were no instrumental deliveries of multiple births, breech, face or brow presentations Outdoors. Indoors, forceps were used to deliver two of the triplets, for the second child in one twin delivery, and in one case to deliver the aftercoming head in a breech presentation.

Table 4.3
Number of, and Indications for, Forceps Deliveries at the ERMH (Indoor and Outdoor) 1890

	1890 Indoor	1890 Outdoor
Forceps Deliveries[a]	48	28
of which:		
Primigravidae	42	12
Grand Multiparae	0	8
Laborious Labour Recorded	41	20
Second Stage of More Than 3 Hours Recorded	26	2
Maternal Deaths Recorded	2	0
Infant Deaths Recorded	4	3
Delivered by Senior Doctor	1	4
Delivered by House Surgeon	47	23
Delivered by Medical Student	0	1
Believed Contracted Pelvis	3	5
Delay in 2nd Stage/Inertia/Rigid Perineum	37	21
Maternal Ill-Health	2	1
Previous Poor History	0	2
Total Deliveries	294	666

Source: ERMH Indoor and Outdoor casebooks, 1890.

[a] This includes one breech delivery with forceps to the aftercoming head.

Table 4.3 shows the data on forceps deliveries by the ERMH in 1890. Comparison between Tables 4.1 and 4.3 shows a major change in practice, in that forceps deliveries had ceased to be the exclusive preserve of the primigravidae. In contrast to the previous years studied, Outdoors in 1890 over half those delivered by forceps were having their second or subsequent baby, whilst half of these were grand multiparae, having their sixth or subsequent child. However, this trend was not apparent in the hospital, reflecting the preponderance of single girls delivering Indoors. The majority of the labours in forceps cases were still described as laborious, and Indoors slightly more than half involved second stages of more than three hours. The reasons given for forceps delivery were now more diverse: Outdoors less than a quarter of the cases (6) were ascribed to contracted pelvis, but a far greater number (21) were categorised as 'delay in the second stage', 'maternal inertia', or 'rigid perineum'. Indoors, in contrast to the earlier years studied, only

three of the 48 cases were ascribed to skeletal problems.[32] Delay or inertia was also the biggest category Indoors. From the second stage times that are available it can be seen that the term 'inertia' always indicated a second stage of more than three hours, whereas on five occasions 'delay' referred to a period of less than three hours.

The outcomes of such shortened labours had also changed: there were only two maternal deaths, both from the brain damage following severe eclampsia, rather than the effects of a long labour and an instrumental delivery. In 1850/1870, a fifth of the mothers had died following instrumental delivery. No mother delivered with forceps for inertia or delay (of whom there were 58) died from any cause. Only seven babies delivered instrumentally for this reason died: six were stillborn whilst the seventh was premature. As dates of admission and demission (dismissal) were not recorded in the new-style Births Registers, any evidence of morbidity Indoors comes by chance through Special and Ordinary Casebook accounts, and in fact there is none; nor is there any evidence from Outdoors. Thus, the use of forceps at the ERMH had not only increased greatly, but, in physical terms of patient survival and health, it had become very successful.

The principal operator at forceps deliveries was now the house surgeon, the assistant physicians only being called twice to Outdoor cases. Mrs Cassidy had a known history of contracted pelvis: she 'had [had] two dead born children previously, with a history of protracted labours. Conjugate of brim evidently about 3 inches - Dr. Milne Murray [assistant physician] applied forceps & delivered child alive on this occasion .... Moulding very extreme'.[33] Presumably his presence was required in case delivery by version proved necessary. Under similar circumstances, Dr Barbour, the other assistant physician, delivered Mrs Baldi by forceps when the house surgeon had failed to do so.[34]

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[32] For example, Janet Anderson 'had a marked projection of the spine in the dorsolumbar region', following back trouble when aged 13 (1890 ICB, case 32 (Prof. Simpson's second quarter) [ARS2] [121/32ss/90si]).
[33] 1890 OCB, case 52 (Dr Halliday Croom's quarter) [JHC] [106/52hc/90so].
[34] 1890 OCB, case 43 ARS2 [250/43ss/90so].

Table 4.4
Number of Other Interventions at Delivery at the ERMH (Indoor and Outdoor) 1890

	1890 Indoor	1890 Outdoor
Manipulative Deliveries	5	3
Expressio Foetus	2	0
Abdominal Operations	1	2
of which:		
Primigravidae	2	0
Grand Multiparae	2	4
Laborious Labour Recorded	2	0
Complex Labour Recorded	3	2
Preternatural Labour Recorded	0	1
Maternal Deaths Recorded	0	3
Infant Deaths Recorded	4	5
Delivered by Ordinary Physician	4	3
Delivered by Assistant Physician	2	1
Delivered by House Surgeon	2	1
Total Deliveries	294	666

Source: ERMH Indoor and Outdoor casebooks, 1890.

Although not as rapidly as forceps, other interventions at delivery had also increased since 1870, from once in approximately every 140 births (0.7%), to approximately once in every 80 (1.4%). In contrast to 1850/1870, there were no destructive operations. Eight deliveries were manipulations by internal podalic version, three were by the abdominal route, whilst two (Indoors) involved the use of 'Expressio Foetus'.[35] Further examination of the other non-forcep interventions reveals more about the hospital and the management of childbirth at this time. Both Indoors and Outdoors such interventions were more likely to be used on parous patients. Four of the five Outdoors patients were grand multiparae, as were two of the eight Indoors.

Podalic version was employed on three occasions Outdoors, twice when forceps had failed. For example, Mrs Morrison had a history of difficult labours, 'all her children having being delivered by forceps or turning'. When strong pains failed to 'advance the head .... [t]he student at the case accordingly sent for the resident on duty'. His

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[35] What this entailed is not immediately obvious: in one case both house surgeons were present and recorded 'Uterine inertia: partial Expressio foetus needed'. The patient, a primigravida, had been in labour for 20 hours and in the second stage for one. (1890 ICB, case 46 JHC [072/46hc/90si]). Haultain instructed that when delivering the trunk whilst the mother was under chloroform, 'if delay,

attempt at forceps delivery failed, and 'the child was therefore turned, the patient being deeply chloroformed. The legs and body of the child were easily delivered but considerable difficulty was experienced with the head which yielded only to considerable supra-pubic pressure combined with traction.' The child was stillborn, and resuscitation failed.[36]

The final case illustrates the unexpected maternal hazards of malpresentation combined with a large fetus. Mrs Moffat, also a grand multipara, and accustomed to an easy labour, 'expected her confinement in April, but carried the child till May. As far as can be gathered from herself the membranes broke at 12pm on the 13th after a prolonged first stage. At 1pm a student saw her but did not recognise the presenting part'. Her pains declined, ceasing completely at 4pm. Help was summoned, 'the woman not collapsed and with a fair pulse'. '[A]n opiate [was] ordered' prior to vaginal examination, at which a uterine tear was felt vaginally. Dr Underhill, the ordinary physician for the quarter, was sent for, and he delivered the child through the rent, retrieving it from the abdomen. After delivery of a 12lb. hydrocephalic child, the patient 'was so collapsed, indeed almost moribund, that it was decided not to attempt to remove her to the hospital for the after treatment'. When this was formally suggested, on the third day, 'neither she nor her relatives would allow it'. She died at home on the sixth day after delivery.[37]

Uterine rupture arising from a transverse lie, this time in an eleventh pregnancy, was also the cause of one of the two abdominal deliveries Outdoors. Dr Berry Hart had 'attempted to draw [the child] back through the rupture, [but] was compelled to desist ... owing to the bowel coming with it'. He carried out Prêvot's operation, improvising a uterine ligature, washing out the cavity with hot water, and applying corrosive sublimate and iodoform gauze, presumably from the delivery equipment present. One of the two house surgeons present 'left for the transfusion apparatus',

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express, but do not pull on head ...' (Francis W. Nicol Haultain *A Practical Handbook of Midwifery* (London: The Scientific Press Ltd, 2nd Edn, 1902), p. 95).

[36] 1890 OCB, case 7 ARS2 [214/7ss/90so]; 1890 Special & Ordinary Casebook [SOCB], facing p. 89. See also 1890 OCB, case 101 ARS2 [308/101ss/90so].

[37] 1890 OCB, case 34 (Dr Underhill's quarter) [CEU] [255/34u/90fo]; 1890 SOCB, p. 76.

and during the operation Mrs Crerar was given subcutaneous saline solution, ether, and brandy by mouth as stimulants. Nonetheless, she died two hours later.[38]

However, the circumstances of the only caesarean section were probably unchanged from those prevailing in 1850. 'Mrs Keir aet 27, 3rd pregnancy' had been 'sitting at the fire talking to her husband when she felt sick and crossed the room to the sink'. There she fainted and fell, striking her head. Her husband and a neighbour 'placed her in bed and then came to the Maternity for assistance'. The medical student sent 'in the ordinary course', found her still unconscious, so 'he ordered hot bottles and at once sent for the House Surgeon'. When he arrived she was pulseless, so in turn he sent for Berry Hart, whose quarter it was. She died 15 minutes after his arrival. 'After some unavoidable delay (the husband hesitating to give his consent) Dr. Hart performed caesarean section in the hope of saving the life of the child.' The child was stillborn, and could not be revived.[39]

In contrast, only one abdominal operation was carried out within the hospital, and this was also for uterine rupture. Georgina Pettigrew was found to have had a prolapse of cord and hand (a shoulder presentation), and the house surgeon failed to replace the cord.

> She continued with few & infrequent pains until about 8am. when a stronger pain coming on she thought she felt something give way.
>
> On exam. in the morning Dr. Underhill found that rupture of the uterus had occurred & Prof. Simpson & Dr. Murray were called in & a Laparotomy decided upon.

Prêvot's operation was carried out successfully on this occasion, and after six weeks of careful nursing she was discharged having 'progressed very favourably'.[40]

Podalic version was used on five occasions within the hospital. In two instances it was used to deliver through a contracted pelvis, once in a primigravida, but once in a

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[38] 1890 OCB, case 110 (Dr Berry Hart's quarter) [DBH] [157/110bh/90fo]; 1890 SOCB, pp. 67-8. This case was published, as D. Berry Hart, 'On the Treatment of Rupture of the Uterus', *EMJ*, XXXVI pt.1 (1890), pp. 35-9.
[39] 1890 OCB, case 98 DBH [145/98bh/90fo]; 1890 SOCB, p. 66.

grand multipara with known pelvic problems. Mrs McLachlan was well-known to the ordinary physicians, and advised to come from Linlithgow for delivery as '[p]atient's legs were bowed when young and she did not walk till 5 years old'. She had no living children. With her first she had 'no instruments no chloroform in labour a long time' before delivering a stillborn son, and she had also had four instrumental deliveries, including two inductions at seven months. In January she had seen Professor Simpson, who had recommended this again, but despite being 'written to twice and advised to come in ..., she delayed doing so till the 8th month'. Her motives in delaying are not discussed in the records: one can imagine she wished to give the baby a greater chance of survival, but she may also have felt fear for herself. When she came in, labour was induced: 'Dr Hart turned, ruptured the membranes and pulled down a leg. Delivery was accomplished by traction from below by the chief and by pressure on the uterus above by the House Surgeon'. The child was resuscitated, but died 22 hours later.[41]

On two occasions version was used to effect a rapid delivery in cases of placenta praevia, in one instance in an emergency patient. Mrs McGlincey, a grand multipara of 31, 'having been sent from Leith in a cab', was admitted in a state of collapse. She had haemorrhaged at home and consulted a local doctor, who 'ordered her to the maternity'. Once in the hospital her condition was stabilised, and a diagnosis of placenta praevia made under chloroform. Rapid delivery followed. She remained in bed for two weeks, and 'was finally discharged quite strong' after a further week.[42] The final delivery by version was again to hasten delivery, this time in a cardiac patient when 'the p[atien]t was in imminent danger'. With careful nursing after delivery both she and her baby recovered.[43]

Thus, the data on intervention deliveries in 1890 suggests that changes were taking place both in the medical management of childbirth, and in popular attitudes to medical care. Major changes in medical strategy can be seen, especially in regard to

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[40] 1890 ICB, case 38 CEU [144/38u/90fi]; 1890 SOCB, p. 80.
[41] 1890 ICB, case 38 DBH [064/38bh/90fi]; 1890 SOCB, p. 64.
[42] 1890 ICB, case 30 DBH [056/30bh/90fi]; 1890 SOCB, p. 62.
[43] 1890 ICB, case 39 ARS2 [128/39ss/90si]; 1890 SOCB, p. 97.

the management of pelvic disproportion. This is shown in the data on forceps deliveries. Previously these had been apparently reserved for women whose first labour was clearly obstructed, whilst those with known pelvic problems were delivered by version, with the primary intention of saving the mother's life. By 1890 this was not necessarily the case. As shown above, Mrs McLachlan was delivered by version, as would have happened 20 years before, but, in the case of Mrs Cassidy, a trial of forceps was successfully made. However, this use of forceps was not the only change: the greater part of the overall increase in instrumental deliveries resulted from deliveries carried out to end labours prolonged for soft tissue reasons, summarised as 'delay' or 'inertia'. This was undoubtedly a more invasive approach to delivery, as criticised by some feminist writers, but, as will be seen in section 4.4, it was not associated with increased use of chloroform. Such a new assessment of labour also implies a change in the function of the birth attendant, who was now required to judge the quality of the patient's physical effort, and express this in language that possessed moral overtones, rather than merely waiting to catch the baby. Whilst this must have altered the relationship between patient and attendant, in 1890 there is no evidence of any response other than acceptance of prescribed interventions by patients. As in 1850/1870, wider evidence also supports this acceptance. The older women in Jalland's study acknowledged that obstetrics, and the use of forceps, had improved greatly during the second half of the century.[44] Further change is apparent in that, in contrast to 1850/1870, the great majority of forceps cases were now delivered by the house surgeon, acting on his own responsibility. This was in sharp contrast to the consultation between senior doctors that occurred before such deliveries in earlier years.

The reasons for this change in delivery strategy are multiple, but individually inconclusive. Undoubtedly, a role can be suggested for the introduction of a rigorous antisepsis policy similar to that used in surgical wards, posited by Halliday Croom in a paper presented to the Edinburgh Obstetrical Society in November 1880, and apparently applied Indoors from August 1880. However, in his routes of infection, Croom lists the 'crushing and bruising … from the prolongation of the labour as well

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[44] Jalland, *Women, Marriage and Politics,* p. 148.

as the application of instruments'. This implies that whilst he did not see tedious labour as harmless, he saw instruments as an additional hazard, and did not envisage antisepsis to be the means to using them more frequently.[45]

The change in delivery strategy may have resulted from technological innovation. In general terms, with the exception of Prêvot's operation, in the late nineteenth century the hospital continued to intervene at delivery using what was basically eighteenth-century technology, made less painful by the use of anaesthesia and less dangerous by the use of antisepsis. However, Munro Kerr, in his analysis of changes in obstetrics between 1850 and 1900, emphasises the improvements in forceps design that occurred in the last quarter of the nineteenth century, particularly the axis-traction forceps developed by Alexander Simpson and Robert Milne Murray. He believes these to have been pivotal in the management of contracted pelvis and to have led to a reduction in the use of podalic version.[46] It is unfortunate that on the only occasion when the type of forceps is mentioned in ERMH 1890 data, it is to record '[a]xis-traction forceps applied by Dr. Duncan but they failed to move head. Turning was then resorted to & the child delivered still born.'[47]

Nonetheless, the displacement by forceps delivery of delivery by version suggests increasing confidence in the use of instruments had developed. The relegation of routine forceps deliveries to the house surgeon shows that, by 1890, it had become a mature and stable technique that could be shared with less experienced people. (The significance of this with regard to house surgeons' status is discussed in Chapter 5). It also suggests that the cases themselves had become more routine and therefore subject to protocol, rather than being perceived as exceptional, and their treatment being the result of a one-off clinical discussion and decision. In addition, at a practical level, doing away with the delay caused by the house surgeon asking his senior for assistance would have decreased the number of cases which delivered normally whilst waiting for him to arrive.

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[45] John Halliday Croom, 'The Systematic Use of Antiseptics in Midwifery', *EMJ*, XXVI, February 1881, pp. 712-21.
[46] Munro Kerr et al, *Historical Review of British Obstetrics and Gynaecology*, pp. 74-6.
[47] 1890 OCB, case 7 ARS2 [214/7ss/90so].

However, despite technological developments and antisepsis, no change would have been possible without its widespread acceptance among those who delivered Outdoors. The fall in associated maternal and infant mortality from prolonged labour due to soft tissue problems suggests a reason for popular acceptance of this increased medical interference. Whilst the vulnerability of the single girls who still made up the vast majority of in-patients must always leave a question about the degree of positive acceptance within the hospital, the increase in the number of parous patients with problems Outdoors suggests that they willingly accepted medical interference. Among pregnant women served by the dispensary, it was evidently now recognised that attendants would be provided from the ERMH who could safely deliver those who, from previous experience, anticipated problems. However, there were obviously limits to patients' acceptance of medical care. Mrs Moffat elected to stay at home, whilst the fact that admission to the hospital was still viewed with suspicion by married patients is borne out by the staff's willingness to continue to treat major problems within the patient's home. It is noticeable that the one independent induction carried out in 1890 was Outdoors, in a twin pregnancy with incipient eclampsia. Further, the hospital's reputation was still limited: as in 1870, only one married woman with no personal Edinburgh connection, but a poor obstetric history, came for help.

4.2.3 Intervention in Labour and Delivery at the ERMH, 1912

By 1912 there had been further change in the management of intervention in the Indoor and Outdoor practice of the ERMH. Figure 4.3 shows that there had actually been a slight percentage fall from the 1890 figure in interventions Indoors, from almost 19% in 1890 to 18%: more significantly, there had been a major decline in the number of interventions effected in the community, from 4.5% to approximately 2%. Figure 4.4 shows in more detail the increasing divergence between Indoor and Outdoor practice, which is emphasised when the high number of BBAs is included in the total of normal births. Outdoors these then increase to 90% of all cases. This section addresses the significance of this change, which indicates that by 1912 any intervention more complicated than a forceps delivery was carried out in hospital.

However, inductions ending in an unassisted birth had also increased, from one (Outdoors) in 1890 to ten in 1912, all carried out within the hospital. Although by 1912 half the Indoor patients were married, those being induced were predominantly so (Table 4.5). All were parous, and at least half had no Edinburgh connection. (The changing nature of ERMH inmates has been-discussed more fully in Chapter 3). The reasons given for induction indicate a greater willingness to intervene surgically in pregnancy on the part of the doctors, and a greater acceptance of this by the patients.[48] Table 4.5 shows the quoted indications.

Table 4.5
Indications for Induction at the ERMH, in Number of Cases, 1912

Total Indoor Deliveries	631
Number of Inductions	10
Intra-uterine Death	3
Contracted Pelvis	3
Maternal Ill-health	2
Extra-uterine Pregnancy	[α] 1
Not Recorded	1
No Recorded Edinburgh Connection	[β]5?6
Patient Married	9
Patient Single	1

Source: ERMH Indoor Casebook, 1912

[α] See text.
[β] One place name not traced

Three induction patients suffered an intra-uterine death, two in advance of labour. Both of these had attended doctors connected with the ERMH elsewhere (not as ERMH patients) and were advised to come into the hospital, rather than awaiting delivery. For example, Mrs R[49] of Glasgow 'consulted Dr HF [Haig Ferguson, assistant physician] because she felt ill & had not felt life for a week. He advised her to come to RMH.'[50] However, Mrs Ux of South Queensferry had been recommended

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[48] For details of the legal and moral anxieties raised by induction of premature labour, see Loudon, *Death in Childbirth,* p. 134.
[49] The names of individual patients in 1912 have been coded.
[50] Her five previous children had also been stillborn. (1912 ICB, case 128 (Dr Haultain's quarter) [FWNH] [128/128/hault/1912i]; 1912 SOCB, pp. 102-4).

to the ERMH by her family doctor. Her first pregnancy had ended in a long labour and craniotomy by him. 'As Dr. Dickson does not care to repeat the experience (sic) he thinks pat. sh'd be admitted to R.M.H.' Despite both the house surgeon and Haultain himself questioning the GP's findings and diagnosis of contracted pelvis, they proceeded with the induction at 38 weeks: the baby was stillborn after an induction lasting six days, but a short and easy labour.[51]

Three induced patients had contracted pelves: two had poor histories, but the third was an inmate of the Lauriston Home (see Chapter 3, section 3.4.3-.4), and 'Dr Young sent her across on account of great contraction of pelvic inlet'. Examined under chloroform by Haultain, it was found that the '[h]ead would just engage in Brim so he decided to induce Premature Labour'.[52] Mrs L underwent her second very early induction due to extreme rickets: she was 'only able to go about on crutches, until recently when she has been too weak and easily made breathless',[53] whilst Mrs U had one living child from seven pregnancies, due to pelvic problems. 'Prof Sir Halliday Croom induced premature labour ... the child was born .... [h]ealthy & alive. Patient was well - but tired.'[54] In contrast to 1890, when Mrs McLachlan had to be coaxed to attend, these three cases show that early induction as a solution to the problem of contracted pelvis in patients of any parity had become acceptable to both doctors and patients.

Two patients were induced because of the effects of worsening eclampsia on their health: Mrs X, of Peebles, was '[r]ecommended [by] Dr Gunn ... because of amount of albumen ... and other symptoms considered by him to be Pre-eclamptic'.[55] In the case of Mrs H her deteriorating condition forced a reversal of the initial recorded decision not to induce.[56] This again shows that it was now acceptable to interrupt a

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[51] 1912 ICB, case 69 FWNH [69/069/hault/1912i]; 1912 SOCB, pp. 49-50.
[52] 1912 ICB, case 106 FWNH [106/106/hault/1912i]; 1912 SOCB, pp. 75-7.
[53] 1912 ICB, case 141 (Dr Barbour's quarter) [AHFB] [285/141/barb/1912i]; 1912 SOCB, p. 162.
[54] 1912 ICB, case 108 JHC [577/108/hc/1912i]; 1912 SOCB, p. 247.
[55] 1912 ICB, case 20 FWNH [20/020/hault/1912i]; 1912 SOCB, pp. 4-5.
[56] 1912 ICB, case 130 AHFB [274/130/barb/1912i]; 1912 SOCB, p. 157.

pregnancy for the benefit of the mother. The final induction of labour culminated in an abdominal section for an extra-uterine pregnancy. [57]

In addition to these induction cases, two of the 24 abortions recorded were induced on the grounds of maternal ill health. Overall, the increase in the number of inductions indicates a much more pro-active practice by the doctors, and a greater social acceptance of intervention in the progress of a pregnancy. However, the presence of so many non-Edinburgh patients, almost all married, confirms that induction was a specialist technique.

However, forceps deliveries were still the predominant form of intervention at delivery, occurring once in every nine deliveries Indoors (11.4%). Outdoors they had dropped to one in every 43 deliveries (2.3%), compared with one in 24 in 1890 (4.2%). As can be seen in Table 4.6, only a third of those delivered Outdoors with forceps were primigravidae, whilst approximately a tenth were having their sixth or subsequent child. The commonest recorded reasons were tedious labour (nine cases, six of whom were primigravidae), and contracted pelvis (four cases, two parous).[58] The latter category were all Leith cases, implying that Leith residents were more reluctant to be delivered in hospital in Edinburgh. All Outdoor cases were delivered by the junior house surgeon or his locum, although in two cases the senior house surgeon was also present.

Within the hospital, indications for forceps delivery were more varied. Two-thirds of the patients were primigravid, whilst half were single. Delay in the second stage was again the largest single indication, and of the 17 patients thus formally classified, only three had a second stage of less than three hours.[59] Pelvic disproportion was suspected only in a twelfth of Indoor cases, proportionately less than Outdoors (one in eight cases), whilst maternal ill-health (12 cases) was the second largest indication for forceps delivery in the hospital, seven such cases being due to eclampsia. Four of these patients were sent in by their GP, with the implication that without their illness

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[57] 1912 ICB, case 44 FWNH [44/044/hault/1912i]; 1912 SOCB, pp. 31-5.
[58] No reason was given in 16 cases.

they would not have delivered at the ERMH. The other sick patients comprised two with cardiac problems, two hysterics, and a grand multipara with 'tonic vomiting'. Forceps were now also used to deliver in some cases of accidental haemorrhage and in one case of lateral placenta praevia. Of these five cases, three mothers survived, as did two babies. The passage of meconium-stained liquor was now recognised as a sign of fetal distress and thus an indication for instrumental delivery. Only one baby of the four so identified was stillborn. This may indicate a new willingness to intervene for the sake of the child.

Table 4.6
Numbers of, and Indications for, Forceps Deliveries at the ERMH (Indoor and Outdoor) 1912

	1912 Indoor	1912 Outdoor
Forceps Deliveries	73	31
of which:		
Primigravidae	50	11
Grand Multiparae	9	2
Laborious Labour Recorded	44	13
Second Stage of More Than 3 Hours Recorded	31	11
Maternal Deaths Recorded	5	0
Infant Deaths Recorded	18	4
Delivered by Senior Doctor	8	0
Delivered by House Surgeon	65	[a] 30
Believed Contracted Pelvis	6	4
Delay in 2nd Stage/Inertia/Rigid Perineum	28	12
Maternal Ill-Health	12	0
Haemorrhage	5	0
Fetal Distress	7	0
Total Deliveries	631	1302

Source: ERMH Indoor and Outdoor Casebooks, 1912

[a] Includes three deliveries by a locum. Additionally, one forceps delivery is unattributed, and not included in the total.

The great majority of cases were delivered by the house surgeon. Senior doctors were more likely to be involved in cases of haemorrhage or ill-health. However, in two of the 15 cases where no obstetric cause was given, patients were delivered by senior doctors as part of their teaching role. Agnes R, a domestic servant, 19 years old and having her first baby, was delivered by Halliday Croom as 'Forceps -

[59] Six were delivered by forceps for inertia, two for a rigid perineum and three for 'tedious' labour.

Demonstration to Clinique',[60] after a second stage of 30 minutes. Mrs H was treated similarly by Dr Ferguson.[61]

These two cases raise a number of questions about the management of forceps deliveries at the ERMH, and about the hospital's attitude to its patients. The use made of Agnes R, above, and others, does imply dubious treatment of vulnerable single patients, and it could be argued that that the ERMH took advantage of a large group of single unsupported girls, treating them as teaching material, and exposing them to un-necessary instrumental deliveries. Socially, forceps patients did form a distinct group compared with those delivered by other interventions. A much greater proportion of the Indoor forceps patients, 37, slightly more than half, were un-married, in contrast to the non-forceps intervention group, of whom only one-sixth (7) were un-married. Further, delay was the commonest reason given for forceps delivery among the single girls,[62] a diagnosis that can be questioned because it requires a degree of qualitative assessment by a possibly biased attendant. However, it should be noted that the definition of delay apparently in use in 1912 was much less rigorous than that applied in the 1970s, for example. Single girls were more likely to have a long second stage, as they were more likely to be primigravid.

However, the pattern of use by the local community suggests that un-necessary delivery by forceps. if indeed it occurred and was known outside the hospital, was not considered a deterrent. At least five-sixths of all forceps patients were local.[63] This can be compared with the non-forceps intervention group, a third of whom had no recorded Edinburgh connection, having come to the hospital from outwith the city in search of expertise (Table 4.8). Further, almost half of the forceps patients were married, and Mrs H was treated similarly to Agnes. Despite the example of the clinique cases, it is hard to sustain the view that ERMH doctors routinely took advantage of a submissive patient population. However, it does provide a sharp

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[60] 1912 ICB, case 82 JHC [550/082/hc/1912i].
[61] 1912 ICB, case 138 JHC [606/138/hc/1912i].
[62] Delay was recorded in 18 of the 37 cases; no reason was given in eight.
[63] The only Edinburgh connection for five is that they were inmates of a 'mother and baby' home.

contrast to the antipathy to forceps (of both doctors and patients) observed in 1850/1870.

Outdoors, delivery by forceps was very safe. There were no maternal deaths, and only one incident of pyrexia, initially associated with abdominal pain, and treated by daily vaginal douches. The patient had recovered by day 10.[64] There were no neonatal deaths, but there were four stillbirths. Indoors, five mothers died, three as a result of eclampsia, and two from haemorrhage. Three were pyrexial: one developed erysipelas and was transferred rapidly to the 'City Fever Hospital', whilst two others recovered particularly slowly. One had been admitted with eclampsia, complicated post-natally by low-grade pyrexia and a swollen sore leg: she first got out of bed on day 37.[65] In another case pyrexia followed a traumatic delivery and haemorrhage. When her 'sutures [were] removed ... it was seen that the parts had not healed by first intention owing to bruising of vaginal walls during delivery'. Her temperature and pulse 'began to swing so antistreptoccocal serum 20cc administered every 24hrs with good effect'. She first mobilised on day 16 and was discharged on the 25th day after delivery.[66]

Maternal and perinatal mortality varied markedly according to the indications for forceps delivery. Table 4.7 shows that a sick mother delivered by forceps because of her illness, had approximately a one in three chance of death, whilst for her baby it was one in two. When the indication for forceps delivery was a contracted pelvis, a quarter of the babies died, whilst all the mothers survived. As in 1890, the mother again had every expectation of survival when the indication for delivery was delay or inertia, but 12% of the babies died. In normal deliveries at the hospital in 1912 the perinatal mortality rate was approximately 8%.

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[64] 1912 OCB, case 82 AHFB [273/82/barb/1912o].
[65] 1912 ICB, case 96 FWNH [96/096/hault/1912i]; 1912 SOCB, p. 87-9.
[66] 1912 ICB, case 56 FWNH [56/056/hault/1912i]; 1912 SOCB, p. 72-4.

Table 4.7
Numbers of Maternal and Perinatal Deaths According to the Indications for Forceps Delivery at the ERMH (Indoor and Outdoor), 1912

	Delay/ Inertia	Maternal Ill-health	Contracted Pelvis	Reason for Forceps Not Recorded
Forceps Deliveries	41	17	11	27
Maternal Deaths	0	5	0	0
Perinatal Deaths	5	8	3	4

Source: ERMH Indoor and Outdoor Casebooks, 1912

Between a quarter and a fifth of the singleton babies delivered by forceps in 1912 died in the perinatal period, compared with a twelfth in 1890.[67] In total, 16 babies delivered by forceps were stillborn, whilst eight died still in the care of the hospital. However, the apparent decline in the quality of care was not the result of contemporary management of delay in labour, when the death rate was similar to that in 1890. The increasing number of admissions for maternal ill-health had a lowering effect on the survival statistics for the hospital: 11 perinatal deaths resulted from eclampsia, haemorrhage, or contracted pelvis. Where forceps delivery was uncomplicated by maternal ill-health, outcomes for both mother and baby were good. The increase in perinatal deaths, and the persistence and increase in maternal deaths at the hospital, was very largely the result of an additional complicating factor, itself the reason for the mother's admission to the ERMH.

The increasing use made of the ERMH as a place of last resort for general practitioners with complicated obstetric cases can be seen even more clearly by examining in more detail the non-forceps intervention cases which occurred in 1912 (Table 4.8). The commonest technique continued to be internal podalic version. In percentage terms, this technique had recovered its position from 1890, when it comprised 7% of Indoor interventions: in 1912 17.5% of interventions involved version. There had also been a steep increase in abdominal surgery and craniotomy, each now comprising 9% of interventions at delivery.

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[67] Table 4.7 excludes seven babies delivered by forceps for fetal distress, of which four died.

Table 4.8
Numbers of Other Interventions at Delivery
at the ERMH (Indoors only) 1912

	Forceps Deliveries	Manipulative Deliveries	Abdominal Operations	Destructive Operations
Number of Cases	73	20	10	10
of which:				
Primigravidae	50	5	1	6
Grand multiparae	9	5	0	2
Believed Contracted Pelvis	6	1	6	9
Maternal Ill-Health	12	4	2	0
Haemorrhage	5	6	0	0
Fetal Distress	7	2	0	0
Malpresentation/Soft Tissue Delivery Problem	0	7	0	1
Maternal Death in Labour	0	0	1	0
Reason for Intervention not Given	15	0	1	0
Maternal Deaths Recorded	5	5	3	3
Infant Deaths Recorded	19	15	3	10
Delivered by Ordinary Physician	5	4	5	2
Delivered by Assistant Physician	3	1	4	2
Delivered by House Surgeon	65	15	1	6
Transferred to Hospital by GP	5	6	6	6
Transferred to Hospital by Districts	0	6	0	2
No Recorded Edinburgh Connection	7	6	5	1
Patient Married	36	17	9	7
Patient Single	37	3	1	3

Source: ERMH Indoor casebook, 1912

However, the usage of podalic version had changed somewhat from that of the earlier years studied. Apparent contracted pelvis only featured in one case: Mrs W was admitted at her GP's request following a failed forceps delivery outside, with the implication of disproportion. 'Forceps were applied with the head above the brim .... Dr. Schoolbred then attempted turning and got down a leg but the head still remained above the brim'. In the hospital Ballantyne carried out the delivery, still with some difficulty: the baby did not survive.[68] This was one of five version deliveries carried out by senior doctors: in contrast to 1890, the principal operator was now the house surgeon, with apparent supervision taking place once.[69]

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[68] 1912 ICB, case 38 (Dr Ballantyne's quarter) [JWB] [354/038/bal/1912i]; 1912 SOCB, p. 175.
[69] See 1912 ICB, case 22 FWNH [22/022/hault/1912i].

In seven cases version was used to deliver a transverse lie: all the mothers survived, as did two of the babies. Three of these patients were transferred from the districts in early labour, whilst Mrs H was recommended by Dr Blackstock, Dalkeith. After she had laboured for two days, '[h]er doctor examined her ... & diagnosed transverse presentation. The membranes ruptured while he was so doing. Pat[ient] was sent to Hospital & admitted at 10.30pm'. The child was born alive.[70]

In six cases, version was used to deliver patients presenting with placenta praevia. Two such were referred to the hospital by their family doctor, in one instance following a consultation with Haultain at the patient's home.[71] Two mothers and four babies died. Version was also used to deliver four sick patients rapidly: three were eclamptic, whilst the fourth had 'leucaemia'. In two cases version was used to deliver following cord prolapse: one child survived. These cases were both sent in from the hospital districts.

Ten patients underwent abdominal surgery, six being delivered by caesarean section, one by abdominal section (mentioned above) and three by pubiotomy.[72] The overwhelming cause was contracted pelvis, and abdominal surgery can be seen to have replaced version as an elective procedure. With one exception, these patients were parous, and had been variously advised by their family doctor, or a hospital consultant, to attend the ERMH if they wished a live child. The primigravida was single, but wished a live child 'as she is to be married as soon as well again'.[73] From the extremely detailed descriptions of the three deliveries by pubiotomy which occur in the Special and Ordinary Casebook, it is evident that the technique was new to the ERMH. In each case a mother who had despaired of a live child was successfully delivered, and no long-term ill effects were recorded. However, the investment in post-operative nursing was high. Each woman spent three weeks on bedrest, completely supine for the first five days.

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[70] 1912 ICB, case 150 JHC [618/150/hc/1912i]; 1912 SOCB, p. 246.
[71] 1912 ICB, case 98 AHFB [242/098/barb/1912i].
[72] Pubiotomy or symphysiotomy opened the contracted pelvis, and thus made vaginal delivery possible. See Loudon, *Death in Childbirth*, pp. 132-3.

In one case a previous birth injury, probably arising from contracted pelvis, necessitated caesarean section. Admitted in labour, Mrs Bj's cervix failed to dilate and Haultain recommended surgical delivery. Neither mother nor child lived.[74] Two other cases failed to survive delivery by caesarean: in one, details are minimal, the patient dying two days later of peritonitis following intestinal obstruction,[75] whilst the other directly mirrored the circumstances in which caesarean section was performed in 1850 and 1890. The mother was already dead:

> [a]ltho' there was some doubt as to whether the child was living or not yet post mortem Caesarian Section was performed & the child extracted. The child was dead.[76]

This was the only abdominal case where the house surgeon rather than a senior doctor operated. Not surprisingly, it is in abdominal operations that the ERMH's role as a centre of excellence or last resort for a much greater area than Edinburgh and its suburbs can be seen: half of these patients had no Edinburgh connection, and four were recommended to the hospital by their GP.

Those delivered by craniotomy were, on the other hand, overwhelmingly local. Only Mrs R came from outwith Edinburgh: 'Dr Cross [Linlithgow] thought the promontory was marked, so after labour had lasted for 3 days she was sent in to the Roy. Mat. Hos'.[77] He may have been expecting other intervention. Six patients were referred to the ERMH by their GP, whilst Mrs X was sent by the Cowgate Dispensary, following a failed delivery in her home.[78] In all cases the operation of craniotomy was indicated by failure of the fetal head to descend through a contracted pelvis. Although maternal outcomes from craniotomy reflected its typically emergency role, and were not good, it was not necessarily an emergency operation. Annie L, an unmarried dressmaker of 'very short stature - & small .... W[oul]d not consent to Op'n for live child .... Dr Lackie wished to do a pubiotomy [when she

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[73] 1912 ICB, case 28 FWNH [28/028/hault/1912i]; 1912 SOCB, pp. 15-16.
[74] 1912 ICB, case 125 FWNH [125/125/hault/1912i]; 1912 SOCB, pp. 97-101.
[75] 1912 ICB, case 79 JHC [547/079/hc/1912i].
[76] 1912 ICB, case 101 JHC [569/101/hc/1912i]; 1912 SOCB, pp. 228-229.
[77] 1912 ICB, case 29 JHC [497/029/hc/1912i]; 1912 SOCB, p. 210.

went into spontaneous labour] but Pat[ient] refused so craniotomy decided on .... performed by Dr Lackie in front of clinique'.[79]

The increase in craniotomy cases illustrates further changes in maternity care in Edinburgh, and at the ERMH. It does not necessarily mean that there was an overall increase in pelvic disproportion in the population, or a change of management, but rather that both GPs and patients now saw the hospital as a suitable place to treat an emergency: the earlier small number of emergency admissions had largely concealed such cases. Six of the group were primigravid: one parous patient had had a previous destructive operation. In five cases forceps delivery had been unsuccessfully attempted, usually by the patient's own doctor. At this point the decision appears to have been taken to deliver to save the mother without regard for the baby, although in three cases the heart was still heard. Ultimately, the mother's life was of more value than the child's. In the case of Mrs M, who had been in labour for five days, 'Sir Halliday Croom was rung up & came to see the patient & decided that all operative treatment to save the child was quite out of the question so craniotomy was fixed upon.'[80] It is not clear from the account whether this decision was based on the mother's condition, or reasonable anxiety about the baby's. The majority of cases were delivered by the house surgeon, usually after consultation.

Overall, there had been little recorded development in technology since 1890, but it was now more actively applied. By 1912 the ERMH had apparently established a reputation among its clientele, local doctors, and students. However, whilst the norm among its patients was to deliver naturally at home, when the 1912 Outdoor data is compared with that from 1890, there seems to have been little resistance to admission if it was thought medically necessary. This can be seen in the type of intervention at delivery carried out at the patient's home in the two years. Further, local and not-so-local doctors had begun to use the hospital as a resource when they had serious problems. This affected the hospital's apparent levels of care, as it was

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[78] 1912 ICB, case 54 JHC [522/054/hc/1912i]; 1912 SOCB, pp. 218-19.
[79] 1912 ICB, case 38 FWNH [38/038/hault/1912i]; 1912 SOCB, pp. 23-4.
[80] 1912 ICB, case 23 JHC [491/023/hc/1912i].

drawing in sick patients from outwith the Edinburgh area, thus increasing its intervention cases.

Although, during the period 1844-1914 the adoption of the new general medical technologies of anaesthesia and antisepsis had made the technology of intervention in childbirth apparently much safer and certainly less painful, modifications in forceps design notwithstanding, it was the same technology that had been described in the eighteenth-century or earlier. However, some applications differed, especially in the case of internal podalic version. The one area of change was the development of abdominal operations on the living patient, whose problems were now better understood and treated.

The difference between the beginning and end of the period under examination lay not in the type of technology, but in the manner in which it was used, and in its apparent acceptance by patients. It can be argued that casebooks provide poor evidence of patient consent or compliance, since their content is controlled by the medical world itself. However, when the evidence of the changing nature of ERMH patients presented in Chapter 3 is combined with the recorded increase in intervention and the evident move from home to hospital for intervention, it can reasonably be suggested that there was increasing patient acceptance of this aspect of medicalisation.

Overall, the hospital data show that by 1890 intervention was more widely used, and by 1912 more pro-actively, and with increasing authority and confidence. Both the applications and methods of intervention were standardised, as is evident in the increasing technical demands made of house surgeons, and in the routine demonstrations by senior staff in cliniques of the use of instruments to medical students. The ability to set protocols that this implies has significance for both knowledge of midwifery, in that events could now be reliably predicted, and for attendants. Greater skill was now required from them in the assessment of labour, to bring each patient to medical judgement. In addition, the rise in intervention cases illustrates the changing function of the hospital, which by 1912 was recognised and

accepted by GPs and patients as a place of expertise. This also has professional implications for the hospital staff, who, as will be seen in Chapter 5, acquired status from their expert role.

4.3 Normal Deliveries at the ERMH 1850-1912

Throughout the period under review, normal deliveries[81] provided the bulk of the work of the ERMH, although Figure 4.2 shows that there was a decline in their proportion between 1870 and 1890. By 1912 there was clear divergence between Indoor and Outdoor practice, although the approximately 15% increase in Outdoor BBAs[82] since 1890 masks the effect (Figure 4.4). This section discusses the evidence about the treatment of normal deliveries in both the hospital and the dispensaries, and for a miscellany of topics connected with childbirth in general. It argues that within the large number of normal deliveries attended by ERMH staff, there was also evidence of increasing medicalisation and standardisation of maternity care. It also suggests that medicalisation was not accepted wholesale by patients, particularly those delivering in their own homes.

Although normal cases formed the major part of the hospital's Indoor and Outdoor work, much less information is available about their treatment, apart from a three-month period in 1870 when details of every hospital case were recorded in the Special and Ordinary Casebook. This illustrates the lack of medical interest in the normal, whilst the lack of explanation demonstrates the immediate nature of the casebooks. They were written for their time, and their readers were meant to have prior knowledge of the general circumstances against which the cases occurred. However, it is not that there is no data concerning normal cases, but at least in the early period, it tends to illustrate the social aspects of hospital care in childbirth, rather than any medical treatment offered. Nonetheless, changes recorded in the data suggest the development, over time, of greater medical interest and institutional

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[81] That is, without any recorded intervention prior to delivery, not necessarily problem-free. The data here excludes multiple births and breech deliveries, both considered at the time to be 'preternatural', as opposed to natural, and recorded cephalic malpresentations, such as face or brow presentations, even when these delivered without intervention.

[82] Cases where the baby was born before the arrival of either the dispensary staff at the home, or the mother at the hospital.

involvement in the normal delivery and puerperium, both in and outside the hospital. This change in content may itself indicate the increasing medicalisation of normal birth.

There is very little evidence overall for the scene at delivery, either in the hospital or on district, although there are some clues. In several instances in the hospital in 1870 the woman in labour was accompanied by one of the midwives, who called the house surgeon as delivery approached.[83] Outdoors in the same year, some patients at least were visited first by the house surgeon before being allocated to students, although this was not always the case.[84] In 1850 and 1870, students (male and female) went to Outdoor cases either singly or in pairs. However, by 1890 almost every dispensary case was attended by not only two medical students, but also by two pupil midwifery nurses. One can speculate, supported by evidence of contemporary Indoor care, that the nurses' function was to provide nursing care for the parturient mother and an antiseptic field for the delivery by students, but nowhere is this explained in any contemporary source. References are only made to nursing care when there was a medical cause for concern.[85] By 1912 all normal Outdoor cases were cared for solely by pupil midwives. The physical position of the mother at delivery was likewise only recorded if it was in some way exceptional,[86] which combines with the advice of contemporary textbooks and lecture notes to suggest that left-lateral was, or was becoming, the norm.

Equally, the presence and involvement of the patient's 'friends' is usually only mentioned in the casebooks once the patient's case has ceased to be normal, when they are frequently deemed to have interfered.[87] However, 'friends', that is, relations

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[83] 'I was called at 4am by the nurse', (1870 SOCB, p. 54); 'I was sent for but found Mrs. Sutherland had delivered the patient before I reached the ward ...' ([1870 SOCB, p. 62).
[84] 'Dr. Kennedy first attended & afterwards entrusted the case to me ...' (1870 OCB, case 5255 [057/5255/70so]); 'Mr. Robertson (student) was called to see this case ...' (1870 SOCB, p. 36).
[85] See, for example, 1890 SOCB, p. 61.
[86] Treating Jane McKenzie for an impacted anterior lip of cervix, Edward Rouse wrote that he 'kept her on her back and applied a binder' (1870 SOCB, p. 93). Treating Mrs R for contracted pelvis, A. G. Hunter attempted forceps delivery, then attempted it again 'in Walcher's position ... still no avail'. (1912 SOCB, p. 210).
[87] 'The relatives – after a good deal of talking had been got through - finally agreed ...' (1870 SOCB, p.40); 'Statement of friends in regard to the Labour previous to admission .... The friends say the

and neighbours of the labouring woman who came to comfort, support, and assist her, and can be seen as the heirs of the more formal 'gossips' who are described as attending early modern births,[88] seem to have continued to be present.[89] Lecturing in 1851, Simpson evidently expected 'friends' to be present at a labour when he advised his students to try to restrict the number.[90] If there were a genuine decline in their presence at labour, as implied by their comparative absence from the casebooks, it would indicate that the mother was encouraged to place a greater reliance on the medical personnel present, such as a nurse, if only because there was no one else. If, as seems more likely, their absence is the result of a failure to record their presence, it indicates that the 'friends' were seen as significant to the hospital only if they had some effect on a hospital function.

4.3.1 Length of Ante- and Postnatal Stays

In both 1850 and 1870 the older style of Birth register allows analysis of patients' dates of admission and demission (discharge) in relation to their delivery date. This permits some examination of patients' perceptions of the purpose of the ERMH, and discussion of when patients were considered ready for discharge, particularly regarding later ideas of bedrest after delivery.

In 1850 it can be seen that a sizeable group (approximately a third) of patients stayed for a week or less, after which they felt themselves well enough to leave the hospital (Table 4.9). With one exception, these patients were admitted in labour,[91] and more than half delivered quickly. All recovered rapidly.[92] They were almost equally divided between married and single, and almost all lived in Edinburgh and Leith. For them, the hospital provided primarily a location in which they could give birth with

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urine was not drawn off and examined.' (1890 SOCB, pp. 71-2); 'Vaginal examination made by patient's mother with dirty fingers before arrival of nurse' (1912 Students' External Casebook (Leith Branch) [SECB(LB)], case 67 [67/067/1912/Leith]).

[88] Wilson, *Making of Man-Midwifery,* p. 25.

[89] They were still there in the 1930s. Molly Muir describes their importance in her memories of being a pupil midwife in Edinburgh in 1934. (Lindsay Reid *Scottish Midwives: Twentieth Century Voices* (East Linton: Tuckwell Press, 2000), p. 37).

[90] Mackay, Heads of Lectures, Vol.1, p. 140.

[91] That is, the admission date is one day or less before the delivery date: two if a long labour was recorded.

free attendance. Their short stay indicates that early mobilisation after delivery was acceptable to this class, and to those who looked after them. Their actions are compatible with the short convalescence encouraged by among her patients by Martha Ballard, some 40 years before, in the pre-industrial American township of Hallowell.[93] However, such early rising does call into question (as does Ballard's practice and the evidence from nineteenth-century Ayrshire) the universality of lying-in for a month, as described by Wilson, and discussed in Chapter 2 (section 2.6).

Table 4.9
Number of Indoor ERMH Normal Delivery Patients Whose Total Stay was Seven Days or Less in 1850

Data available for normal cases	208
Stayed Seven Days or Less	81
Ante-Natal Admission	1
Labour of Twelve Hours or Less	48
Prolonged Second Stage (more than 3 hours)	8
Prolonged Labour (more than 24 hours)	2
Primigravidae	27
Parous	54

Source: ERMH Indoor Casebook, Register of Births, 1850

The remaining patients stayed for eight days or more, half of these staying in excess of eleven days (Table 4.10). Unsurprisingly, this group contained all those who had a prolonged labour or second stage, and five women who could be considered unwell. Three of these were still present in the ERMH on day 11, whilst the fourth was transferred to the Royal Infirmary on that day, for undeclared reasons. Reasons for ill-health included haemorrhage at delivery, possible manual removal of placenta, and 'hysterical convulsions', whilst one woman was described as deaf and dumb.

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[92] That is, they were described as 'well' in the 'condition on discharge' column, and their casebook entry contains nothing to contradict this.
[93] Laurel Thatcher Ulrich *A Midwife's Tale: The Life of Martha Ballard, Based on her Diary, 1785-1812* (New York: Vintage Books, 1991), pp. 189-91.

Table 4.10
Number of Indoor ERMH Normal Delivery Patients Whose Total Stay was Eight Days or More in 1850

Stayed Eight Days or More	127
Labour of Twelve Hours or Less	84
Prolonged Labour (more than 24 hours)	2
Prolonged Second Stage (more than 3 hours)	24
Not Well	5
Ante-Natal Admission	40
Primigravidae	67
Parous	60

Source: ERMH Indoor Casebook, Register of Births, 1850

All bar one of the ante-natal admissions were also in this group, and their circumstances illustrate well the hospital's social function (Table 4.11).

Table 4.11
Number of Ante-Natal Admissions to the ERMH Culminating in Normal Delivery, 1850

Total Ante-natal Admissions	41
More than 14 days before delivery	21
More than 31 days before delivery	9
Married	8
Single	13
Parous	10
Home Address outside Edinburgh/Leith	9
Born outside Edinburgh/Leith	16
Partner absent	9
Not Well	2

Source: ERMH Indoor Casebook, Register of Births, 1850

In 1850 almost one-fifth of normal delivery cases were admitted ante-natally. Half of these (20) were admitted in the two weeks before the expected date of delivery, as directed by the Hospital Rules,[94] but half were admitted earlier in their pregnancy. Some of the 'overstays' may be ascribed to post-maturity, but almost half of this

[94] *Rules and Bye-Laws,* 'Patients', paras. 1-6, pp. 3-4.

subgroup were admitted more than 31 days before they delivered. Curiously, those whose partner was absent and who had been born outwith Edinburgh, and who therefore appear more friendless and in need of charity, were more likely to be admitted between 14 and 31 days before delivery, when post-maturity can reasonably be blamed for an excessive stay. Those who apparently flouted the rules by being admitted more than 31 days before delivery were more likely to belong to Edinburgh or Leith, and be in contact with the baby's father, whilst less likely to be married than those in the main 'overstay' group. Perhaps they had a better measure of the charity.

Only two of the ante-natal admissions were described as sick at any point. Overall, the evidence of the ante-natal admissions to the hospital in 1850 suggests that their applications were made as a result of their social circumstances, and not for medical reasons. Discrepancies were due to either charitable disregard for their own rules by the management, or deception by potential patients.

By 1870, a longer convalescence was evidently more popular, and only 14 patients were discharged in a week or less, although some were considered fit for discharge by then. The great majority of normal delivery patients stayed for more than seven days postnatally, with a sizeable group staying for more than eleven days.

Table 4.12
Post-Natal Stays of Indoor Patients after Normal Delivery at the ERMH in Number of Cases, 1870

Total Data available	85
Stayed Seven Days or Less	14
Stayed Eight Days to Ten Days	39
Stayed Eleven Days or More	32
Not Well Eight Days after Delivery	18
Ante-Natal Admission	25

Source: ERMH Indoor Casebook, Register of Births, 1870

At eight days, 18 patients were described as unwell in some way, but this had reduced to 6 at 11 days post-delivery. They are recorded as suffering from, and being

treated for, a variety of complaints. Five were of longstanding, phthisis or venereal disease, but most were puerperal problems. Two babies could not be nursed. The accounts of these women's complaints and their treatment indicate increasing medical interest in the minor problems of childbirth.

In 1870 a third (54) of those patients for whom information is available were admitted ante-natally, rather than in labour (Table 4.13). Half of these (28) were admitted more than 14 days before they delivered, whilst 16 were admitted more than 31 days before delivery. In contrast to 1850, those who were admitted earliest in their pregnancy were most likely to have been born outwith Edinburgh, or have no recorded Edinburgh connection. Some of these had probably also been abandoned by their male partners, since in nine instances his address, if known, bore no relation to that recorded for the patient. Three partners were in America. However, Mary Reddie's husband William was in service as a house steward in Perthshire, and her circumstances suggest the use of the hospital as a substitute home for those in tied accommodation with no other family.[95]

Table 4.13
Number of Ante-Natal Admissions to the ERMH Culminating in Normal Delivery, 1870

Total Data Available	159
Admitted in Labour	105
More than 14 days before delivery	28
More than 31 days before delivery	16
Married	4
Single	23
Parous	14
Home Address outside Edinburgh/Leith	6
Born outside Edinburgh/Leith	19
Partner Absent	[a] 11
Not Well Ante-natally	3

Source: ERMH Indoor Casebook, Register of Births, 1870

[a] Nine of these were admitted more than 31 days before delivery.

[95] 1870 ICB, case 1706 [009/1706/70si].

Only three of the patients admitted ante-natally who delivered normally were sick, two with longstanding problems. Jane Maynard 'ha[d] worn tube in Trachea for 3 years',[96] whilst Jessie Chisholm was a 16-year-old with syphilis.[97] Helen Milne had a breast abscess. This was opened and drained by the house surgeon, but it continued to cause trouble post-natally, and the baby was put out to nurse.[98] However, the overall impression is that among those who delivered normally, ante-natal admissions continued to be for social, rather than medical reasons.

Due to the changes in the Births Register, there is less information available on the admission and discharge of well patients in 1890, as dates of admission and demission were no longer recorded. However, census data throughout the latter half of the century implies that at any time the norm was for a quarter to half of the patients to be ante-natal.[99] From accounts in the Special and Ordinary Casebook, albeit of sick patients, the length of postnatal stay was becoming standardised at approximately 10 days. The only detailed records of ante-natal problems for the majority of patients with normal deliveries come from the 'Remarks' column of the casebooks. Indoors, two had syphilis and one had left-sided paralysis, presumably of longstanding. Jane Thomson's case was described in detail. A known cardiac, she returned to Edinburgh from her married home in Stockton-on-Tees to be delivered in the hospital where she had been treated before. She was '[a]bout a fortnight from term: and suffering from great anasarca and dyspnoea'.[100] Outdoors, ante-natal health problems were recorded four times: one patient had had typhoid fever at five months, another had cardiac disease, whilst two had been victims of domestic violence.

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[96] 1870 ICB, case 1616 [032/1616/70fi].
[97] 1870 ICB, case 1783 [086/1783/70si]
[98] 1870 ICB, case 1736 [039/1736/70si]; 1870 SOCB, p. 29.
[99] That is, they had no baby. In 1851 there were five such patients and six postnatal (with infants); in 1861, 10, with six postnatal; in 1871, four, with one postnatal; in 1881 two (and eight postnatal), and in 1891, four, with four postnatal. (N. R. and S. Carstairs (compilers), *Edinburgh 1851 Census*, Volume I, *The Canongate,* (Scottish Genealogy Society, 1993), p. 279; Registrar-General for Scotland [RGS], *Census of the City of Edinburgh,* Registration District 685[4], 1861, Enumeration Book 97; 1871, Enumeration Book 70; 1881, Enumeration Book 81; 1891, Enumeration Book 75).
[100] 1890 ICB, case 6 JHC [032/6hc/90si]; 1890 SOCB, pp. 82-5.

Considerably more evidence about the management of normal cases, particularly in the puerperium, is available for 1912, as by then Students' External casebooks were kept, and these record the daily visits made until the tenth day. From this it can be seen that the great majority of Outdoor patients were discharged on the ninth or tenth day. However, there is little information from inside the hospital. As in 1890, there is no longer evidence of length or type of stay for well patients. Of those who delivered normally in the hospital in 1912, 34 were unwell (8.2%). Eight were treated as eclamptic, whilst seven had suffered antepartum haemorrhage. Eight were 'unintended admissions', sent in by either the districts or their own doctor when they became ill, although they had originally made different plans for their delivery. There was therefore a small increase in the maternal mortality of the 'normal delivery' group.[101]

In about 1908 Margaret Milne Murray criticised the ERMH for 'certain alterations in the treatment of the patients', evidently instituted in about 1904, which apparently included only admitting patients when in labour, and enforcing discharge on the ninth day after delivery, whatever the patient's state of health. Her criticisms led the Directors to order the end of these measures in 1908, and there is no hint of them in the 1912 data.[102]

In general, the evidence of ante-and postnatal stays at the ERMH illustrates the changing function of the hospital from a social shelter (a change enhanced by the 1904 admission restrictions) to one that provided medical care for sick parturients. However, the changing pattern of discharge indicates the increasing medicalisation of the puerperium. By 1870, few patients appeared to have resumed their normal life in less than a week, and, as will also be shown in the section on mobilisation (4.3.3), by 1912 the hospital imposed a 10-day period of convalescence. In so doing, it confirmed the new role of childbirth as, if not necessarily an illness, nonetheless an event requiring a medically-supervised recovery. Above all, the casebook evidence

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[101] In 1912, 4 out of 414 died; in 1890 1 mother in 204 normal singleton deliveries Indoors died.
[102] Margaret Milne Murray *The Practical Training in Midwifery of the Edinburgh Medical Student: An Appeal to the Senatus of the Edinburgh University, the Directors of the Royal Maternity Hospital,*

shows increasing medical interest in puerperal problems, and increasing standardisation of care.

4.3.2 Perineal Repair

Whilst the 1890 records are extremely brief in regard to normal deliveries, they do contain early references to perineal tears and repairs. In her work on early midwifery, Eccles claims that tears were commonly left unsutured, to facilitate the next birth.[103] Only third-degree tears, involving the anal sphincter, were apparently repaired in the early nineteenth century:[104] in 1890 Jane Cochrane was described as having '[f]issure of perineum, previous tear not united' at her second delivery.[105] By the late nineteenth century fears of infection entering through such an awkwardly-sited wound led to a medical culture of maintaining an intact perineum wherever possible. If this failed, then suturing was suggested, but was not always acceptable to the patient. In 1890 perineal damage was recorded in eleven Indoor cases following normal delivery, and ten of these were stitched. Outdoors it was mentioned in four cases.

In 1912 perineal tears at delivery were recorded in 30 cases on the district (approximately 2.3%), with 19 being sutured. Normally this was a medical decision, but Mrs H, a 26-year-old para 1, '[r]efused to have perineum stitched'.[106] Leith also recorded a large number of old, unrepaired tears,[107] a finding that possibly indicates the recent move of the ERMH into Leith. Within the hospital, although there are no accounts of perineal incisions, 55 patients (13.3%) required perineal sutures. The introduction of comments on perineal repair, and the surgical repair of the tear itself, suggests a change in established custom and provide further evidence of increasing medicalisation of normal birth, particularly within the hospital.

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and to the Physicians of that Institution, (printed privately, 1908), pp. 12-13; J. R. Middleton and R. Robertson, ERMH Report by the Sub-Committee for the Board of Directors, 13 July 1908, pp. 4, 6.

[103] Eccles, *Obstetrics and Gynaecology,* pp.105-6.

[104] James Wilson *Truth: a Libel by Law. The Evidence of Sir J. Y. Simpson Bart., M.D., and others, in the case of Sharp versus Wilson, with Correspondence* (Edinburgh: Henry Robinson, 1869), p. 42.

[105] 1890 ICB, case 43 ARS2 [132/43ss/90si].

[106] 1912 OCB, case 93 FWNH [93/93/hault/1912o].

[107] Fifteen, compared with one in the main district.

4.3.3 Mobilisation

From mid-summer 1870 the extra detail of the Special and Ordinary Casebooks gives the first records of mobilisation, when the newly-delivered mother was considered fit to get out of bed. This was recorded for eight healthy patients, three of whom first mobilised on day 4, three on day 5, and two on day 6. From these records, most were considered fit for discharge after a week. This contrasts with later medical advice to new working-class mothers on rest after delivery, and with the postnatal experiences of those higher up the social scale. Patients did not always leave immediately after they had been passed fit for discharge, behaviour which reinforces the picture of the ERMH as primarily a social shelter. Mary Anderson was still in the hospital 14 days after being passed, 'doing light work',[108] whilst Janet Jack stayed until '[s]he ... received a situation as nurse'.[109]

There is no evidence of mobilisation from 1890, and minimal evidence of Indoor practice in 1912: mobilisation was recorded in the Special and Ordinary Casebook for only four patients who delivered normally. All four were unwell, nonetheless two were up on day 3, whilst the others first rose on days 6 and 17. There is considerable evidence of normal practice from the External Casebook. Here bedrest was encouraged. Days of first mobilisation were recorded in 30 cases in the main dispensary and these are almost equally divided between less than a week, seven or eight days, and more than eight, as can be seen in Table 4.14.

Table 4.14
Recorded Commencement of Mobilisation
in Outdoor Patients of the ERMH, in Numbers of Cases, 1912

	All Deliveries (Main Dispensary)	All Deliveries (Leith)
Less than seven days	10	19
Days 7 and 8	11	42
More than eight days	9	91

Source: ERMH Students' External Casebooks for the main dispensary and Leith Branch, 1912

[108] 1871 SOCB, p. 105.
[109] 1871 SOCB, p. 113.

In Leith the day of first mobilisation was recorded for approximately a third of all deliveries: three-fifths of these (91) first got out of bed after more than eight days, but only 19 were recorded as being up after less than a week. Assuming that the patients were genuinely nursed in bed for the periods recorded, and not forced by domestic circumstances to be up and to deceive the nurses in attendance,[110] then this indicates a general acceptance of the medical advice for prolonged bedrest after delivery, as encouraged by Angus Macdonald in 1881. Those who were recorded as being 'up doing household work' early in their puerperium, or as having gone out later in their recovery, were a minority.

Table 4.15
Recorded Days of Discharge in Outdoor Patients of the ERMH in Numbers of Cases, 1912

Day	All Deliveries (Main Dispensary)	All Deliveries (Leith)
3		[α] 2
4		
5		
6	1	
7	2	
8	[β] 7	
9	50	7
10	536	412
Later	12	3

Source: ERMH Students' External Casebooks for the main dispensary and Leith Branch, 1912

[α] In one case the patient's mother was a midwife; in the other she called in a doctor because of the prematurity of the baby.
[β] This includes two cases when the midwives are recorded as being excluded from the house.

Tolerance of the idea of prolonged bedrest and nursing, as advocated by Macdonald, can also be seen in the widespread acceptance of ten days of nursing care before discharge. Table 4.15 shows how few patients discharged themselves early, although there were two cases in the main dispensary when the nurses were not admitted to the house. This was evidently considered grounds for discharge. However, in some

[110] This deception has long been a part of midwifery folklore, and a definite example, from Edinburgh, can be found in Lindsay Reid's oral history accounts of twentieth century midwifery. (Reid, *Scottish Midwives*, p. 37).

circumstances, when, for example, the tenth day approached, or when it was New Year's Day, absence was perhaps more forgivable.[111]

The period 1850-1912 at the ERMH was one of increasing medical involvement in the minutiae of normal delivery and the puerperium, initially by the doctors, but, by 1912, also by pupil midwives. This medical involvement led not only to an increasing recognition of associated pathological problems, but a more careful search for them. This can be seen, for example, in the high number of cases of ragged membranes reported by the pupil midwives in 1912, none of which had any adverse effects on the patient, and only four of which had any further treatment.[112] Puerperal care was thoroughly medicalised: the patients' vital signs were taken daily, comments were made on infant feeding, and the vast majority of mothers were routinely dosed with castor oil. At the same time the ERMH and its dispensaries became responsible for an increasing proportion of births in Edinburgh, caring for a wider social range of patients. The result was that the treatment of patients who had had normal deliveries became increasingly formulaic and institutionalised, both in and outside the hospital. Care was given according to a medical regime. The attitude of the patients to this is difficult to assess. The fact that they used a free service, and, particularly, admitted dispensary staff to their homes, suggests popularity, and from 1890 there are signs that the free provision of expert help for recognised problems was acceptable. However, the early reluctance to be admitted, and the determination of some to return to their daily routine sooner than advised by the medical world, suggests that there was also some resistance to increasing medicalisation. The next section further illustrates this.

4.3.4 BBA Cases

In each of the years 1850, 1870, and 1890, the percentage of BBA cases was very small, being about 1% (Figure 4.2, section 4.2). Unsurprisingly, the majority of these cases occurred in the community, although in 1870 Baby Gillies was described as

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[111] See 1912 SECB(LB), case 464 [479/464/1912/Leith].
[112] The two Outdoor casebooks for 1912 contain 66 mentions of 'ragged membranes', of which four were treated, by douching.

having been 'born in the walk' before arrival in the hospital.[113] By 1912, however, the number of BBAs, both Indoors and Outdoors, had increased significantly, to about 13% in the combined practice. Again, the majority of such cases occurred in the districts (Outdoors), and these will be examined in detail below, but approximately 5% of cases entered in the Indoor records were BBAs, a 4% increase since 1890 (Figure 4.4). These represented two scenarios: when the mother had miscalculated the time left to reach the hospital, and when she developed problems following delivery elsewhere, and was then admitted (Table 4.16).

Table 4.16
Recorded Reasons for Admission to ERMH after Delivery, in Number of Cases, 1912

Total BBA Cases Recorded in Indoor Casebook	33
Born en route to Hospital	4
Post-natal Problem	11
Mother & Baby Home Inmate	1
Precipitate Labour	2
No Details Recorded	15

Source: ERMH Indoor Casebook, 1912

Table 4.16 shows that the recorded number of patients who miscalculated their journey was very small, being basically unchanged at less than one percent of the total number of patients. However, it also shows that a third of all Indoor post-delivery admissions in 1912 were the result of a problem during or immediately after delivery. These can be seen in more detail in Table 4.17.

Identified post-delivery problems leading to admission indicate a number of trends in the development of the ERMH, and in attitudes to childbirth in Edinburgh. One of the two commonest causes of admission was eclampsia (or 'fitting'): this accounted for two of the three medical referrals, one of which was from the associated Cowgate Dispensary rather than a GP attending a private case, and for three of the district referrals. This implies both that eclampsia was now recognised as a hazardous condition, that it could be best treated in a hospital with adequate resources and knowledgeable staff, and that when such advice was given by a retained doctor or

[113] 1870 ICB, case 1770 [073/1770/70si].

dispensary staff, it was now accepted by the woman's family. The case of Alice G, '[s]ent in by Dr - Placenta (bits) retained. $CHCl_3$ [chloroform] - manual removal. Intra uterine douche' further supports the belief that by 1912 the hospital provided a resource for local doctors who in turn approached the problems of childbirth with more circumspection than formerly.[114]

Table 4.17
Recorded Post-natal Problems Leading to Admission to the ERMH, in Numbers of Cases, 1912

Total Post-natal Problems Recorded	11
Eclampsia/Fits	5
Retained Placenta	1
Concealed pregnancy?	5
Poverty	[a] 1
Admitted at Request of Outside Doctor	3
Admitted 'from district'	5

Source: ERMH Indoor and Special and Ordinary Casebooks, 1912

[a] This case is not included in the 'Post-natal Problems' total.

The other most common reason was a concealed pregnancy. This was identified as such in two cases, who were both sick,[115] whilst one can reasonably assume that the management of the Royal British Hotel did not intend one of their barmaids to deliver on the premises.[116] The use of the hospital, rather than the poorhouse at Craiglockhart, as a repository for such women, implies that childbirth and the puerperium were seen, at least by some, as medical conditions requiring a certain level of care. The admission of Mrs H, '[b]ecause of poverty brought into Hospital' by the district staff, also supports this.[117] The increase in admitted BBAs further indicates the increasing medical role of the ERMH.

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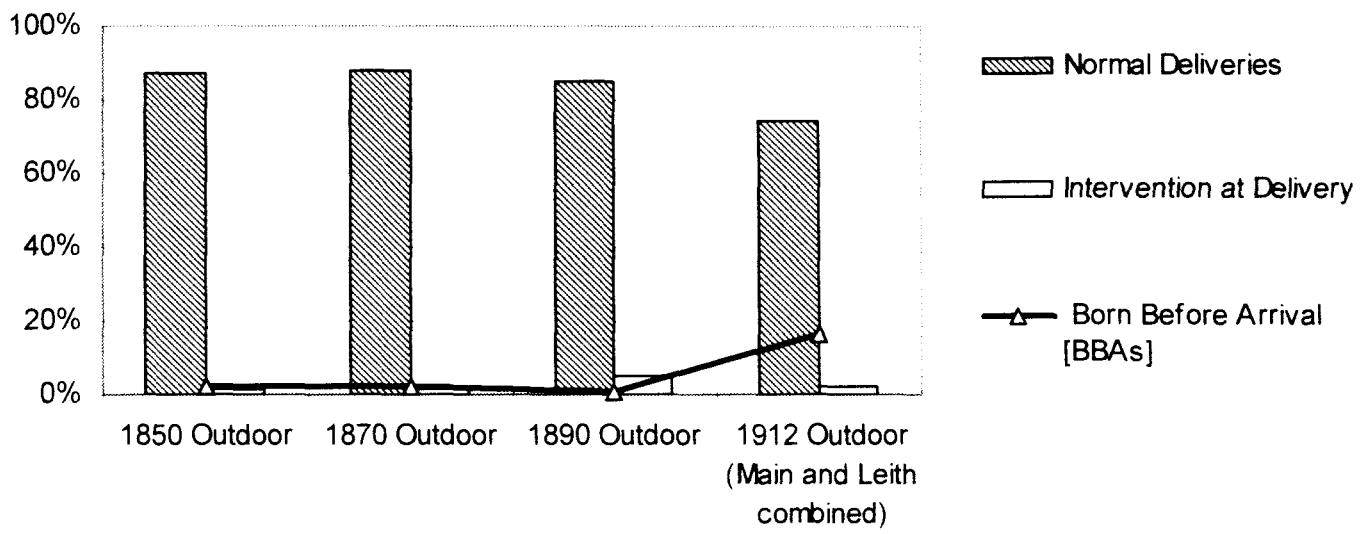
[114] 1912 ICB, Case 83 FWNH [83/083/hault/1912i].
[115] Agnes Ub was a 'servant in Bloomiehall, Juniper Green ... perfectly well during pregnancy which she concealed, doing hard work well' (1912 SOCB, pp. 126-7). Jane O 'delivered herself .... No one was present & the placenta was also delivered when no one was present. She was first seen at noon by the nurses and was delivered at 11 oclock [sic].' (1912 SOCB, pp. 248-50).
[116] 1912 ICB, Case 26 FWNH [26/026/hault/1912i]. The other two cases were entered as '[b]rought into Hospital Baby born outside'.
[117] 1912 ICB, Case 28 JHC [496/028/hc/1912i]).

Outdoors, BBA cases may have had a different significance. In 1912 there were 165 such cases in the main dispensary, 20% of all its recorded cases, whilst in Leith there were 49 BBAs, 10% of their total. In previous years studied, Outdoor BBAs formed 1-2% of cases (Figure 4.5). Such an increase deserves further examination.

Figure 4.5
The Work of the ERMH Outdoor Dispensaries, Showing the Low Incidence of Intervention at Delivery, and also the Increase in BBAs, 1850-1912



Source: ERMH Outdoor Casebooks, 1850, 1870, 1890, 1912, and Students' External Casebook (Leith Branch), 1912

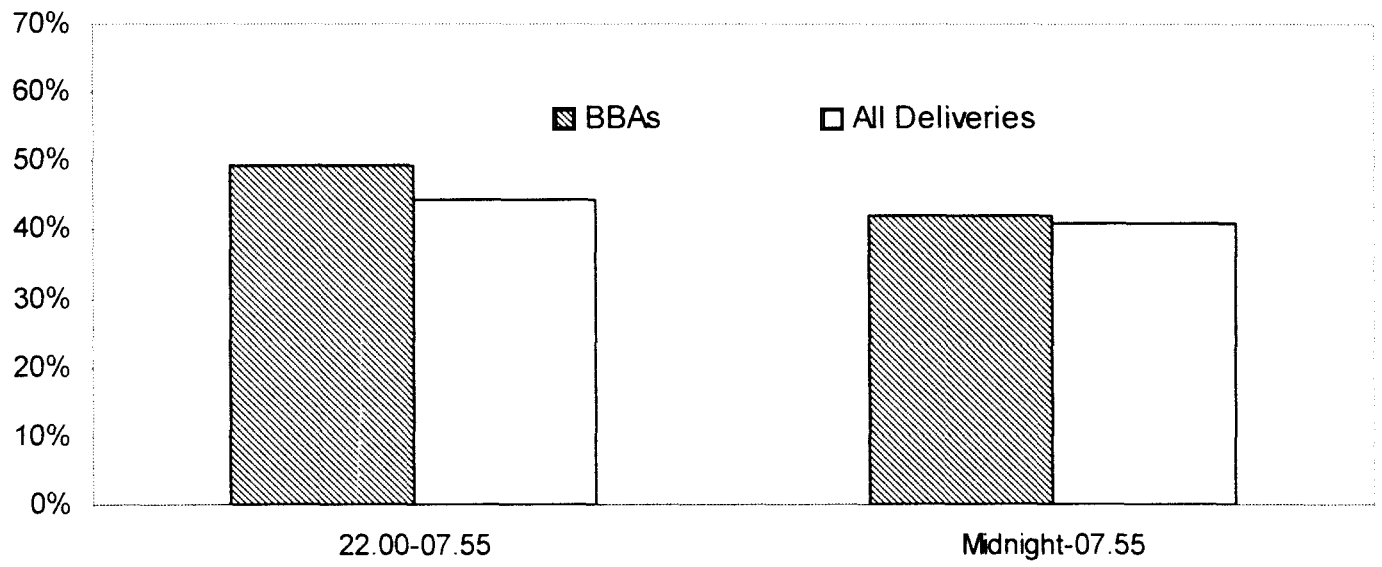
A number of explanations for this increase in BBAs suggest themselves. It might have resulted from a change in recording policy. In July 1908, the Directors claimed that, before that time, when nurses arrived to find the child already delivered, if they thought there was sufficient help in the house they did not go back to visit again, and did not necessarily record the birth in the casebooks. They were instructed to change this practice.[118] It could be assumed that this change would lead to an increase in the percentage of BBAs recorded. However, examination of the Students External Casebooks for 1905-6, before the instruction, shows that 15.6% of the births attended and recorded were BBAs, 14.3% of which were re-visited.[119] By definition, un-recorded and un-visited cases do not show in the casebooks and are unknowable. However, no massive increase in BBA cases was noted in late 1909-10, after

[118] ERMH Sub-Committee Report, 13 July 1908, p. 5.
[119] Students' External Casebook [SECB], cases from 9 January 1905 to 8 January 1906.

recording requirements had changed. Between 25 November 1909 and 2 March 1910, 21% of recorded cases were BBAs, 16% of whom were re-visited.[120]

As a further explanation, the births might have occurred at a time when the dispensaries' resources were overstretched, particularly at night. However, Figure 4.6 shows that it was not the case that there was a significant increase in BBAs between 10 o'clock at night and 8 o'clock in the morning.

Figure 4.6
ERMH Main and Leith Dispensaries Combined:
Time of Delivery for Patients Delivered without Professional Assistance (BBAs), 1912



Source: ERMH Students' External Casebooks for the Main Dispensary and Leith Branch, 1912

Neither were the BBA cases victims of an overall shortage of staff. In every month with the exception of March, over half the Main Dispensary deliveries were attended by two pupil midwives, although in Leith the norm was for one to attend, suggesting that they were capable of conducting deliveries on their own. There was also little fluctuation in the number of nurses recorded over the year, although the number of BBAs per month varied from nine in July, to 27 in January.

Communication by the labouring woman with the dispensaries may have been at fault. A letter from a patient to the Matron in 1914 indicates that this was not always simple.

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[120] SECB, cases from 25 November 1909 to 2 March 1910.

> Dear Madom this is a not to ask you if you would be as good as to let me no your Number on the telefon as I am not been filling very well all this week and I am afrid it happens on the night so as my Husband will no where to ring up in so as might be no mistake made if you mind you put me down for the first of the month you remeber Mrs. V and I am at the top Flate. I enclose a stamp for you to send me the number with. [121]

However, this would also have been true in the earlier years studied, when BBAs were far fewer. Further, whilst the ERMH claimed in its 1907 Annual Report that the Leith branch was intended primarily to provide additional delivery experience for pupil midwives intending to sit the Central Midwives Board examination, its existence should have reduced the number of geographically distant cases attended by the main dispensary.[122] A brief examination suggests that there was little difference in distance from the ERMH in the areas of Edinburgh inhabited by BBA and non-BBA cases. Overall, it seems unlikely that the increase in BBAs from 1890 arose either from communication difficulties or deficiencies in the management of the two dispensaries.

Did the patients of the BBA group therefore differ in any measurable way from those whose deliveries were attended? It could be suggested that the rapid labours of increasing parity (at least until the uterine muscle weakened) might predispose to an unattended labour. Of the Outdoor patients whose parity was recorded,[123] 446 were grand multiparae, having their sixth or subsequent child, whilst 60 of these were having their eleventh or subsequent baby. However, it can be seen from Figure 4.7 that whilst the percentage of grand multiparae who delivered without professional help is slightly greater than the norm, on the whole the BBA group did not vary a great deal in parity from the entire group.

Although the great majority of the BBA patients had had personal experience of labour, something different about their body's response might have led to non-recognition of labour on their part. It can be seen from Figure 4.8 that the combined

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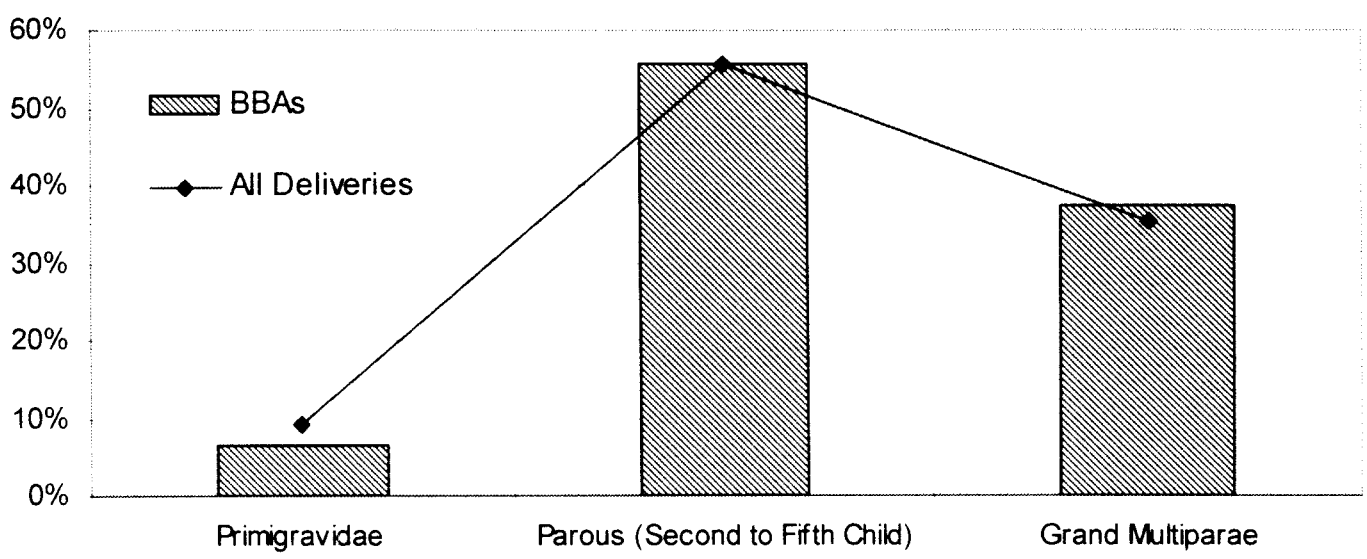
[121] This letter, dated 30 October 1914, and transcribed as written, is loose within the first Indoor Casebook in the possession of the Royal College of Physicians of Edinburgh.
[122] However, there were only four cases in Leith in 1890.

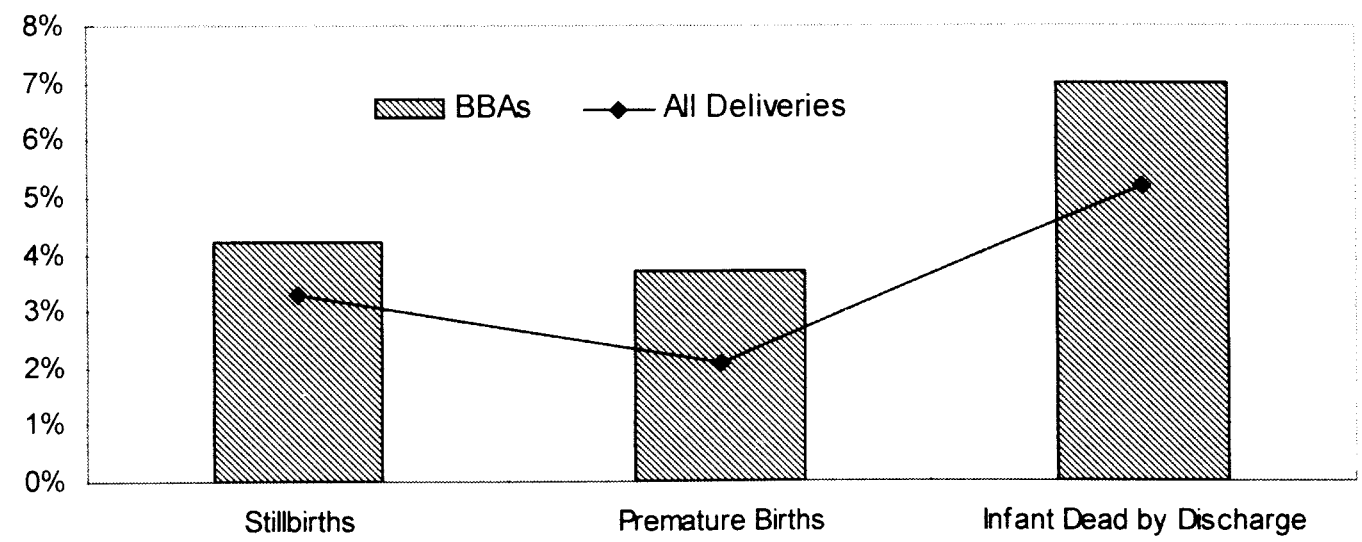
group yielded a higher than average percentage of stillbirths and premature births, and therefore of infants who were recorded as dead on discharge. Such a sad birth outcome affected 15% of this group, in comparison with a norm of 10.6%. When the individual dispensaries are compared (Table 4.18), it can be seen that in Leith, in particular, the BBA group had much higher proportions of still- and premature births.

Figure 4.7
ERMH Main and Leith Dispensaries Combined: Parity Distribution of Patients Delivering without Professional Assistance (BBAs), 1912



Source: ERMH Students' External Casebooks for the Main Dispensary and Leith Branch, 1912

Figure 4.8
ERMH Main and Leith Dispensaries Combined: Showing the Proportions of Stillbirths, Premature Births, and Infants Dead by Discharge in Professionally Unattended (BBA) and Normal Deliveries, 1912



Source: ERMH Students' External Casebooks for the Main Dispensary and Leith Branch, 1912

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[123] It was only left unrecorded in 4 instances amongst the deliveries.

Table 4.18
Percentages of Stillbirths, Premature Births, and Infant Deaths in Professionally Unattended (BBA) and Normal Deliveries at the ERMH Main Dispensary and the Leith Branch, 1912

	BBAs[a] (Main Dispensary)	All Deliveries[a] (Main Dispensary)	BBAs[a] (Leith)	All Deliveries[a] (Leith)
Stillbirths	3.6	3.6	6.0	3.0
Premature Births	2.4	1.2	8.0	3.3
Infant Dead by Discharge	6.6	5.3	8.0	4.8

Source: ERMH Students' External Casebooks for the Main Dispensary and Leith Branch, 1912

[a] Excluding all abortions.

A further cause for the increase in BBAs may lie not in the management of the dispensaries, nor in the nature of the individual pregnancy, but in a consumer response to the increasing regimentation of childbirth, largely implemented by the ERMH, which through its associated dispensaries oversaw approximately 30% of Edinburgh births by 1912. In addition, since the 1907 Notification of Births (Scotland) Act, the attendant at the birth was required to notify the authorities of the birth, in addition to the registration of the birth by the father. It is possible that some dispensary patients hoped to deliver with their friends and family around them, but planned to avoid the notification problem by calling for assistance late in the labour. The evidence for this, which is admittedly scanty, almost all comes from Leith. Mrs P delivered without hospital assistance, and two days later requested that the nurses' visits stop, as 'Patient's mother a midwife': she was accordingly discharged.[124] Whilst Mrs I was delivered by a dispensary nurse, her mother, who had examined her daughter vaginally prior to the nurse's arrival, was obviously playing an active role in proceedings.[125] On two occasions all stages of the birth were described as complete 'before nurse was sent for',[126] and on a further eight this is entered more innocuously as 'before the arrival of the nurse'.[127] In the main dispensary Baby K was described as 'born 3 hours before nurse was called'.[128] However, in contrast to 1909-10, all such patients were re-visited, although some exceptional cases were

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[124] 1912 SECB(LB), case 105 [105/105/1912/Leith].
[125] 1912 SECB(LB), case 67 [67/67/1912/Leith].
[126] For example: 1912 SECB(LB), case 280 [290/280/1912/Leith].
[127] For example: 1912 SECB(LB), case 417 [430/417/1912/Leith].
[128] 1912 OCB, case 59 FWNH [59/59/hault/1912o].

discharged early (see sections 4.3.1 and 4.3.3). Any rejection of the services of the hospital did not extend into the postnatal period, and the great majority of BBA cases were discharged routinely on day 10. Some were recorded as mobilising early: in Leith six of the eleven BBA cases whose first mobilisation was recorded were described as 'doing household duties' by day 8,[129] whilst in the main dispensary Mrs B was entered as 'gone to Haddington' on day 9.[130] However, most BBA cases remained in Outdoor care until discharge on the tenth day, only rising for the first time on day 9 or 10.

The diversity and, in some cases, the paucity of the evidence make it impossible to identify a single reason for the increase in Outdoor births which were recorded in the ERMH's casebooks although the birth itself was not attended by hospital staff. The evidence of the casebooks does not suggest that it was the result of lack of staff or poor communications in the dispensaries. Some scanty evidence implies partial rejection or manipulation of dispensary care by the patients, in response to increasing regimentation.

4.4 The Management of Pain at the ERMH

The understanding and recognition of pain in labour underwent considerable change during the nineteenth century. Until the mid-century, even after the discovery of chloroform, the view prevailed amongst men-midwives that childbirth was a physiological process, in which the need for assistance was small, and the attendants' role was to watch and wait. Coping with the pain was considered within the resource of the majority of women. However, in the later years of the century the view developed, largely in the United States but adopted in Britain, that modern civilised women were no longer able to deliver naturally and painlessly, and required analgesia and increasing intervention in labour.[131] Access to pain relief for all was

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[129] For example: 1912 SECB(LB), case 170 [170/164/1912/Leith].
[130] 1912 OCB, case 70 JHC [708/70/hc/1912o].
[131] Loudon, *Death in Childbirth,* p.340-3. Loudon notes that whilst this became a commonly held view within the English-speaking world, it was not adopted in mainland Europe.

one of the causes embraced by early feminists, and in part led to the foundation of the National Birthday Trust in 1928.[132]

Due to the presence of James Young Simpson, Edinburgh was closely associated with the development of anaesthesia and its application to childbirth. In January 1847 Simpson adopted Morton's 1846 discovery of the anaesthetic effects of ether for use in childbirth, but found it difficult to administer and unpleasant for the patient. Experiments with chloroform revealed that it was effective, easily portable, and pleasant to inhale, and by November 1847 Simpson had used it on fifty labouring women.[133] Following John Snow's reputed administration of chloroform to Queen Victoria in 1853, antipathy to its use, which had partly resulted from Simpson's combative advocacy of the drug, largely disappeared.[134]

The use of anaesthesia potentially represented a significant change in the understanding and approach to childbirth. The demand for pain relief, if met by chloroform (thus removing the mother from an active role in her child's birth), could be considered to medicalise birth *per se*, by allowing it to be dominated by medical requirements. However, the attitudes of both patients and doctors to anaesthesia were mixed. Nineteenth-century obstetricians have been accused by modern, feminist writers of abusing chloroform, relying on its anaesthetic properties to hurry labour and delivery.[135] However, Carter and Duriez claim (based on Simpson's writings), that women welcomed chloroform and pushed for its widespread use. This contrasts with Jalland's finding that her correspondents, all wealthy and well-connected, saw chloroform only as a last resort, although they appreciated knowledge of its existence.[136] Caton has also examined attitudes to pain in the nineteenth century. He

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[132] A. Susan Williams *Women and Childbirth in the Twentieth Century* (Stroud: Sutton Publishing, 1997), pp. 45, 124-46.

[133] For a detailed analysis of the introduction of chloroform, its effects on the medical world, and Simpson's handling of the medical and religious opposition to its use, see Donald Caton *What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present* (New Haven: Yale University Press, 1999).

[134] Carter and Duriez, *With Child,* p. 118; Loudon, *Death in Childbirth,* pp. 343-6.

[135] Carter and Duriez, *With Child,* p. 118.

[136] Carter and Duriez, *With Child,* p. 51-3; Jalland, *Women, Marriage and Politics,* p. 147-8. However, Woolcock *et al* suggest that there was a psychological aspect, and that those women who were dubious about their child-bearing role, were more attracted to chloroform. (Helen R. Woolcock, M.

sees the century as one in which the abolition of pain became a motive for social reform, and older ideas about the redemptive nature of pain, and the reduced sensibilities of the poor, began to fade.[137] However, Rhodes notes that, even in the early twentieth century, attitudes to pain can be surprising to modern eyes, citing the number of manual removals of placenta performed without anaesthetic at the Hull Municipal Maternity Home.[138] The ERMH data enable examination of the actual use of pain relief and anaesthesia in its hospital and dispensary practice 1850-1912.

Use of pain relief was recorded in each year of this study, either in the casebooks proper, or in the Special and Ordinary casebooks as part of a lengthier description of a case. However, the number of instances was small, begging the question whether these records contain all the uses of anaesthesia or analgesia in that year. In 1850, just over two years after Simpson's first use of chloroform on ERMH patients, only three cases were recorded Indoors (1%), whilst one was recorded Outdoors. By 1870, nine women were given chloroform in labour Indoors, whilst six had chloral, one woman featuring in both groups. This was 7.8% of those delivered in the hospital. Outdoors, however, only four women received such treatment (0.7%). All the Indoor 'anaesthetic' cases which fell in the period when the surviving Special and Ordinary Casebook for that year was also being completed (after July 1870) were recorded in both books. In 1890 there were 15 instances where anaesthetic drugs were exhibited Indoors (4.8%), including an occasion when ether was also given (subcutaneously) as a cardiac stimulant. However, only six of the occasions when chloroform was used were recorded in the main casebook: the other cases are known only from their entry in the Special and Ordinary Casebook. Outdoors, 12 of the 15 cases are recorded in the main casebook, with three entered solely in the Special and Ordinary

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John Thearle, Kay Saunders, ' "My Beloved Chloroform" Attitudes to Childbearing in Colonial Queensland: A Case Study', *Social History of Medicine*, 10 (1997), pp. 437-57). In contrast, Leavitt believes American women pushed for its use against the wishes of their doctors (Leavitt, *Brought to Bed*, pp. 116-19).

[137] Caton, *What a Blessing*, pp. 122-9.

[138] Maxine Rhodes, 'Municipal Maternity Services: Policy and Provision 1900-1939 with Particular Reference to Kingston-upon-Hull and its Municipal Maternity Home' (Hull University Ph.D. Thesis, 1996), p. 230.

Casebook.[139] By 1912, information on 46 of the 50 patients recorded as receiving pain relief can be found only in the Special and Ordinary Casebook accounts. Such patients constitute 7.9% of all those Indoors; Outdoors, 1.5% of patients in the Main Dispensary, and 3.1% of those in Leith, received pain relief.

The variable percentage of patients receiving pain relief, and the variation in the site of recording, when taken in conjunction with the increasing number of interventions in labour, suggest more that the anaesthetic record is incomplete, than a very limited use of anaesthesia. With regard to 1912 this theory is supported by the offhand way in which its use has sometimes been added to the casenotes.[140] In 1905 the Medical Board replied to the Directors that chloroform 'had been given in all difficult and specially painful cases, married or unmarried'. Further, they regretted 'that the recording of the ... giving or withholding of chloroform has not been specially mentioned hitherto'.[141] It could be suggested that the use of chloroform had become so routine that the house surgeon no longer thought it worthy of record. A comparison can be made with the 'Record of Confinements' of the Hospice, a contemporary all-female outdoor maternity service also based in Edinburgh, where chloroform was given by a doctor at almost every confinement, whilst the nurse carried out the delivery.[142]

However, additional material from 1912 suggests that the absence of references to chloroform is not solely clerical. On occasions the authors of the Special and Ordinary Casebook expressed admiration at the stoicism of some labouring patients, whilst criticising the behaviour of others, thus indicating that routine anaesthesia was

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[139] Three of these cases involve chloral, as in 1870. Chloral is a mild hypnotic. However, it is evident from the 'Remarks' here that it was thought to stimulate a slow labour: see, for example, 1890 OCB, case 143 JHC [197/143hc/90so]). Its sedative properties were also known and in the 1870 Outdoor Casebook, reference is made to anaesthesia with chloral. (See, for example, 1870 OCB, case 567 [033/567/70fo]).

[140] In 1912 Robina Y was delivered by internal podalic version for a transverse lie. In the account of her case '$ChCl_3$' has been added later in a smaller hand. (1912 ICB, case 46 FWNH [46/046/hault/1912i]; 1912 SOCB, p.39).

[141] ERMH Directors' Minutes [DMERMH]: 16 May 1905.

[142] Lothian Health Services Archive [LHSA], The Hospice, Record of Confinements Vol. II, 24 June 1908 – 30 October 1909.

not the norm.[143] It is reasonable to conclude that whilst probably not every anaesthetised case was recorded as such, a blanket anaesthetic policy was not followed at the ERMH in 1912.

Those cases where anaesthetic was used, however, illustrate some of the attitudes of the ERMH and its staff to their patients, as well as the increasing medical intrusion into childbirth. In 1850 chloroform was used on four occasions, and these indicate the greater complexity of the circumstances surrounding cases involving anaesthetic. In the only Outdoor case, 'The child was turned by Dr. Harley in the presence of Dr. Simpson – Chloroform'[144] although there were three other largely un-anaesthetised version deliveries Outdoors by senior doctors.[145] The implication is that anaesthesia would make this teaching delivery easier for both patient, and doctors. Indoors, chloroform was used only in three normal deliveries: in one instance the patient had 'to fiets [sic] of hysterical convulsions, got chloroform with success'.[146] Anaesthesia was evidently being used here to control uninhibited behaviour due to illness. Pity may have combined with the desire to control behaviour in a further case: Betty Hogg, 30 and having her third child, had a prolonged second stage, when chloroform was used occasionally 'during the 4 hours the head on perineum'.[147]

In 1870 chloral was used in eight cases, six times in the hope of accelerating labour, and twice as anaesthetic. Chloroform was used on nine labouring patients Indoors, four of whom were described as making slow progress, but only one of whom would be ultimately delivered by forceps. However, in a further two cases, the failure of contractions to cause the cervix to dilate was treated by digital dilatation once the

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[143] For example, Mrs J, a 26-year-old primigravida, 'behaved extremely [*illegible*] well all through'. On the other hand, the condition of Mrs D, gravida 6, admitted with a slight ante-partum haemorrhage, was summarised by the house surgeon as '[t]he uterus is contracting slightly and patient is calling out a good deal with the pains'. (1912 SOCB, pp.204, 207).
[144] 1850 OCB, case 3466 [033/3466/50so].
[145] One patient, Mrs Moncur, had found a more accessible form of anaesthesia: her '[c]hild [was] turned by Dr. Moir, patient had been drinking for some days.' (1850 OCB, case 3033 [051/3033/50fo]). Consumption of alcohol was used by some women to dull the pain, to the disapproval of some medical men. (See Loudon, *Death in Childbirth,* pp. 343-4; Wilson, *The Making of Man-Midwifery,* p. 26. For a further Edinburgh example of this, see John Mackenzie *Pigeon Holes of Memory* (London: Constable, 1988), pp. 118-19).
[146] 1850 ICB, case 2164 [074/2164/50si].
[147] 1850 ICB, case 1178 [013/1178/50fi].

patient was anaesthetised. In these examples, and in the only case where a non-labouring woman was anaesthetised, to permit the opening and draining of a breast abscess, one can suggest that the anaesthetic was preserving the modesty of both participants, relieving a different type of pain. In addition, the use of anaesthesia to open the abscess suggests that the house surgeons were not unsympathetic to their patients, nor believed that poverty rendered them less susceptible to pain: its limited use in labour implies that they expected women to cope with the physiological pain of labour.

Chloroform also continued to be used as a means of control, imposing medically-preferred behaviour. Matilda Mather was given chloroform because she 'became so noisy and restless',[148] as was Madeline Howden, 'a sort of imbecile', who 'was getting difficult to manage'.[149] However, the two Outdoor cases involving chloroform illustrate the hospital's developing medical role. In both, the house surgeons were called to deliver a retained placenta at a non-ERMH delivery. Mrs Johnston had already been delivered by 'Mr. Crane (Parochial Dispensary)' of a live boy, but he had to seek help for an adherent placenta, as did the unknown midwife who had delivered Mrs Archibald of twins. On each occasion both house surgeons attended, one manually removing the placenta whilst the other gave the anaesthetic.[150]

By 1890 chloroform was definitely the anaesthetic drug of choice Indoors, with chloral being used only once, to sedate post-natally an albuminuric patient described as 'exhausted and very dyspnoeic'.[151] Chloroform was used before the operative treatment of incomplete abortions, and on occasions when the labouring patient had an additional debilitating condition. Both placenta praevia cases, already weakened by loss of blood, were anaesthetised before delivery by podalic version, as was an uncompensated cardiac whose condition was worsening. Two eclampsia cases were

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[148] 1870 ICB, case 1731 [034/1731/70si]; 1870 SOCB, p. 32. However, 'owing to the patient having been a hard drinker, the chloroform made her unmanageable'. Eventually she inhaled the hospital's entire stock of chloroform without noticeable effect.
[149] 1870 ICB, case 1778 [081/1778/70si]; 1870 SOCB, p. 90.
[150] 1870 OCB, case 5275 [077/5275/70so] (Crane); case 5271 [073/5271/70so] (midwife).
[151] 1890 ICB, case 22 ARS2 [111/22ss/90si]; 1890 SOCB, p. 99.

both given chloroform to control their fits. However, of 40 women described as suffering delay or inertia in labour, only three were recorded as being anaesthetised before being delivered by forceps. Janet Anderson, who had a 10-year history of back trouble and a marked kyphosis, was anaesthetised as she entered the second stage, in accurate expectation of a horrendous forceps delivery.[152] Jane Kennedy's labour was described as 'Long 2nd stage Delayed at perineum. Chloroform Forceps. 3 Stitches.'[153] Maggie Simpson was treated similarly.[154] The increase in forceps deliveries in 1890 was not associated with a recorded increase in anaesthesia.

Outdoors, chloral continued to be used principally to expedite labour, although Euphemia Main , an eclamptic, was given chloral postnatally as a sedative.[155] One of the two slow labourers who had chloral also received three doses of opium. The principal use for chloroform Outdoors continued to be when a manual removal of placenta was required. It was used for this in seven out of the ten occasions when it was given. Again, hospital staff performed this function for deliveries that they had not attended. In the case of Mrs Brooks, a 30-year old gravida 7, presumably the hospital was only contacted because of the problem with the placenta. Her '[c]hild born at 8 a.m. no attendant called from Maternity. Sent for assistance at 12 o'clock: Credé method failed owing to reflex contraction of uterus - yielded under chloroform (Dr. Williams).'[156] Chloroform was also recorded as being used in two out of three version cases, and in the one abdominal operation on a live patient. However, it was exceptional for it to be used in forceps cases: only two out of 27 Outdoor patients were anaesthetised prior to instrumental delivery.

In 1912 the percentage of incidence of recorded pain relief was similar to that of 1870, but the usage, and the range of drugs available, was not. Chloroform anaesthesia was still the most widely used method (36 cases), but morphine analgesia

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[152] 1890 ICB, case 32 ARS2 [121/32ss/90si]; 1890 SOCB, facing p. 100.
[153] 1890 ICB, case 14 DBH [40/14bh/90fi].
[154] 1890 ICB, case 26 ARS2 [115/26ss/90si]; 1890 SOCB, p. 100.
[155] 1890 OCB, case 133 DBH [180/133bh/90fo]; 1890 SOCB, p. 73.
[156] 1890 OCB, case 65 JHC [119/65hc/90so].

was also used, either on its own, or with combined with scopolamine (25 cases).[157] In 11 cases morphine was used in combination with chloroform. Morphine was used principally to sedate rather than to relieve pain, and was given to nine of the 14 eclamptic patients who received treatment to control their fits. However, it was also used in three cases of shock, whilst Mrs H, admitted from 'the District' with painless vaginal bleeding and no sign of fetal life, was '[p]ut to bed with Morph. gr.¼'.[158] Morphine was combined with scopolamine on five occasions, three before operative delivery under chloroform. Presumably it was thought these patients would benefit from the amnesiac effect. In addition, these drugs were given generously in labour to two patients, whose histories illustrate the adverse effect the narcotic could have on the baby. The first, Bella O, was admitted early 'for secrecy': she also refused a caesarean section although she had a small pelvis and a large child. After a long labour in which she had two doses of morphine and scopolamine, culminating in a difficult forceps delivery, the baby required long resuscitation and 'kid reviver'.[159] However, he was more fortunate than Baby girl Bj, who could not be resuscitated, as due to 'Scopolamine & Morphia poisoning ... [she] failed to establish proper respiration.'[160]

Chloroform was used in a range of conditions. Most common were cases in which a contracted pelvis dictated an operative delivery (10 cases), although a further eight involved sick patients, six of whom were eclamptic. In five instances, (but three patients), its use was recorded prior to venesection or gastric lavage, rather than delivery, withdrawing the patient from an unpleasant and painful procedure. Similarly, it was used for both ante- and post-natal vaginal examinations, and for two of the three clinique cases recorded, this time both withdrawing the patient from a painful and embarrassing experience, and allowing the doctor more freedom to examine and to teach.

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[157] For the history and significance of this treatment, known as twilight sleep, see Loudon, *Death in Childbirth,* pp. 346-8, Leavitt, *Brought to Bed,* pp. 136-139, 173, and Carter and Duriez, *With Child,* pp. 167-9.
[158] 1912 ICB, case 20 AHFB [165/021/barb/1912i]; 1912 SOCB, p. 130.
[159] 'Kid reviver' was apparently liquid strychnine. (1912 ICB, case 20 AHFB [164/020/barb/1912i]; 1912 SOCB, pp. 128-9).
[160] 1912 ICB, case 125 FWNH [125/125/hault/1912i]; 1912 SOCB, pp. 97-101.

The pain relief offered can also be assessed in terms of the deliveries at which it was (or was not) used. Only 14 of the 414 patients who delivered normally were recorded as receiving any pain relief, and five of these were anaesthetised after the birth of the baby when there were problems with the placenta. Six of the 73 forceps cases had analgesia: three were eclamptic whilst two had a contracted pelvis. None of the cases where use of forceps was indicated by delay or inertia were apparently anaesthetised. However, only half of the abdominal and manipulative deliveries are recorded as having pain relief, suggesting that this information was not always entered.

Indoors, a wider range of pain relief had not apparently encouraged wider use. Although in over half the cases it was used prior to intervention in labour or delivery (36 cases), in 15 cases it was used primarily to control erratic behaviour due to illness,[161] or to permit public or distressing examination. It was not used for relief in normal labour. However, some cases evidently were felt to deserve analgesia, notably where the operation could be understood as painful by both parties, such as venesection, or when rest was considered exceptionally desirable.[162]

Outdoors the use of analgesia and anaesthesia was less complicated, and either less stoicism was expected of the patients, or the Outdoor casebooks provide a more accurate picture of actual practice. In Leith all bar one of the 10 forceps deliveries received analgesia or anaesthesia, although six of the labours were described as tedious or slow rather than the result of contracted pelvis. However, in the main dispensary only a third of forceps cases received pain relief, although four of their labours were described as tedious. In Leith three of the four problematic placentae were removed under chloroform, although in the main dispensary only three of the twelve cases where the placenta or membranes were manually removed apparently involved anaesthetic. Additionally in Leith, Mrs U , gravida 6, with a transverse lie

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[161] See, for example, 1912 ICB, case 49 FWNH [49/049/hault/1912i]; 1912 SOCB, pp.42-4.
[162] Mrs Uw, admitted with placenta praevia, was '[s]ent to bed with full dose of scopolamine. Slept all night.' (1912 SOCB, p. 148).

and a '[h]istory of haemorrhage [was given] Chloroform ... to facilitate vaginal examination' by Dr Ritchie.[163]

Although the hospital's range of treatment and intervention greatly increased in the period 1850-1912, the use of analgesia apparently did not increase. If the ERMH evidence is sound, then the belief that labour was normally a physiological process, coping with which was well within the capabilities of most women, appears to have survived into the twentieth century.[164] Alternatively, it can be interpreted as showing that ideas on the redemptive nature of pain (or punishment) continued in an institution most of whose inmates were un-married. However, this is not supported by the even lower use of analgesia Outdoors, where most patients were married, or its use when some medical procedures were undertaken. Overall, the management of pain appears to be one area in which there was little medicalisation of childbirth. Whilst there might be more intervention than formerly, it was still expected that the great majority of parturient patients would need no pain relief. Nonetheless, the use that was sometimes made of chloroform does suggest that by subduing those who did not conform, it had a role in the imposition of medical ideas of appropriate behaviour during childbirth. Correspondingly, its use in some procedures, such as venesection, can be interpreted as giving the patient permission to feel her pain, influencing her later understanding of her treatment. Further, its use prior to teaching suggests either concern for the patient, or complete disregard for the human exhibit, with implications for the future behaviour of the students concerned. There is no independent evidence of patient response to the management of pain offered by the ERMH: it has all been recorded by the hospital's agents.

4.5 The Management of Puerperal Infection

Infection occurring at the time of birth was seen as an increasing problem in the nineteenth and early twentieth century, both because of the probable growing virulence of the principal infective organism, and because newly-collected national

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[163] 1912 SECB(LB), case 82 [82/82/1912/Leith].
[164] Further evidence that pain relief was generally considered un-necessary in labour prior to the 1920s can be found in Williams, *Women and Childbirth in the Twentieth Century*, pp. 124-46.

statistics made the number of maternal deaths it caused more obvious.[165] It had a profound effect on medical practice and thought,[166] although little progress was made in reducing the number of cases until the introduction of sulphonamides and antibiotics.

Infection cases themselves came in two principal forms. The smaller group comprised cases that resulted from infection by normal flora of maternal tissue profoundly damaged by prolonged labour and difficult delivery, and probably further debilitated by blood loss and exhaustion. These cases can be recognised by their obstetric history and by the fact they occur in isolation.[167] Far more serious were the exogenous cases. In Europe and America these most commonly resulted from haemolytic streptococcal infection, which caused epidemics of peritonitis or septicaemia.[168] Infection could be spread by direct contact between cases (typically borne by the attending practitioner), and by asymptomatic carriers.[169] Some practitioners might seldom or never see a case, whilst others could have their reputation destroyed by the disease.[170]

By the 1830s the idea that a doctor or midwife could carry infection from a puerperal fever case to a non-infected one was widely accepted, although it had not replaced earlier 'environmental' theories. It was considered good practice to change clothes

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[165] In 1874, an epidemic year for both puerperal fever and erysipelas, it was responsible for 52% of recorded maternal deaths at the time of childbirth (Loudon, *Death in Childbirth,* pp. 48, 70-7). However, Loudon considers early mortality statistics from England and Wales inaccurate, due to the different manifestations of the disease, the complexity of the certification, and the desire of private general practitioners to keep their recorded infection cases to a minimum.

[166] Its frequently iatrogenic nature struck at the heart of a new professional grouping, the men-midwives or obstetricians, by showing that they could bring harm, not help, to their patients. (See, in particular, Alison Bashford *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (London: Macmillan Press Ltd., 1998), pp. 63-83). Once the use of antisepsis at delivery was understood, it became a weapon in the fight for registered midwifery in the hands of Rosalind Paget and Mary Scharlieb, and criticism was made by them of both untrained midwives and general practitioners. (Donnison, *Midwives and Medical Men*, pp. 94-124).

[167] Stanley A. Seligman 'The Lesser Pestilence: Non-Epidemic Puerperal Fever', *Medical History,* 35 (1991), pp. 89-102.

[168] Loudon, *Death in Childbirth,* pp. 53-4, Tables 4.1 and 4.2. These show bacteriological findings in northern England and Aberdeen in the 1920s that indicate the preponderance of streptococcal infections, especially among fatal cases. For a specific focus on haemolytic streptococcal infection, see Irvine Loudon *The Tragedy of Childbed Fever,* (Oxford: Oxford University Press, 2000).

[169] Neither the ubiquity of streptococcal infection, nor the role of asymptomatic carriers, were recognised before the Colebrooks' work in the late 1920s (Loudon, *Death in Childbirth,* pp. 81-2).

and to wash thoroughly before making further visits. Simpson also advocated hand-washing in either chloride of lime or cyanide of potassium.[171] There was a steady interest in the subject in medical journals, and by the 1860s puerperal fever was considered to be epidemic in Britain, and emphasis was placed on improving the environment, with maternity hospitals in particular being heavily criticised.[172] The presence of streptococci in the vaginal discharge of infected patients was first observed in 1865, but in the early years of germ theory these were thought to be the result rather than the cause of the infection. By 1879 their active role was recognised and antiseptic techniques were increasingly used. Early identification of puerperal infection began to be considered essential for isolation purposes: treatment remained problematic and largely ineffective.

It is not clear how much of a threat patients considered puerperal infection to be. During the epidemics in Dublin in 1861-3 and 1867-8, the Master of the Rotunda attempted unsuccessfully to reduce admissions to the hospital, but found that poor patients favoured the certainty of warmth, food and care over the chance of death through infection.[173] Jalland notes whilst her correspondents talked about the possibility of dying in childbirth in general terms, they only mentioned puerperal fever with reference to a specific case, and then often euphemistically. She ascribes this to a conspiracy of silence by medical men, although in other respects her ladies were extremely sceptical of anything told them by their doctors.[174] There are no obvious references to deaths from infection in *Maternity*, although there is much discussion of the debilitating effects of overwork, over-breeding and underfeeding.

Although from time to time puerperal infection affected the ERMH, and following introduction of antisepsis the control of infection became seen as an increasingly important task, the four years studied in detail appear largely free of infection, using

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[170] Ibid., pp. 62-3.
[171] Mackay, Heads of Lectures, Vol.2, p. 198.
[172] Bashford, *Purity and Pollution*, pp. 63-83. The criticism of the infection rates of lying-in hospitals was led by Dr Farr of the Registrar-General's Office, using newly collected death statistics. See also Donnison, *Midwives and Medical Men*, pp. 106-7.
[173] Irvine Loudon, *The Tragedy of Childbed Fever*, pp. 68-9.
[174] Jalland, *Women, Marriage and Politics*, pp. 172-5.

the data recorded. However, they do provide some evidence of the changing response of the hospital to infection, and can be contrasted with years in which minor epidemics occurred.

The first Births Register shows that in December 1848, within four years of the establishment of the ERMH, two deaths from puerperal fever occurred. The response of the management was to discharge the six undelivered patients, and re-house them at the hospital's expense. The numbers recorded in the 1851 census would suggest that this was the entire complement of undelivered patients at the time,[175] with the inference that the hospital was to be temporarily closed. However, it was receiving patients again by late February 1849. The rationale behind the closure seems to have been to remove healthy patients from an area of contagion before they entered their most vulnerable state. The implication that the hospital could discharge its duties towards its pregnant patients by finding alternative lodgings reinforces the belief that it saw its role as largely social.

In 1850 there was some evidence of puerperal infection. One of the four recorded Indoor deaths was from puerperal fever, whilst another patient, delivered 15 days later, was transferred to the Royal Infirmary with a pelvic abscess.[176] A third patient, whose child was born 5-6 weeks later, was also transferred, although no reason was recorded.[177] All three had had unremarkable labours, but each woman was attended by the same house surgeon, William Heude. The hospital management evidently did not consider this an outbreak comparable with that of Christmas 1848, and there are no records of closure, or discharge before delivery. It is unclear whether Heude restricted his practice in any way: he continued to attend cases throughout the period from the first affected delivery to the transfer of the last case, but he attended far fewer than his fellow house surgeon, John Landell. One of the three Outdoor deaths in 1850 was ascribed to 'gastric peritonitis'; this occurred four days after a long

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[175] Carstairs, *Edinburgh 1851 Census*, Volume I, *The Canongate*, p. 279.
[176] 1850 ICB, case 2159 [069/2159/50si]; 1850 ICB, case 2171 [081/2171/50si].
[177] 1850 ICB, case 2195 [105/2195/50si].

labour and forceps delivery by Dr Thompson. No other case appears associated with this death.[178]

Throughout the Birth Register entries for the 1850s and 1860s, there are occasional records that suggest possible further outbreaks of infection. In 1855 two women died in April and May, whilst in early June a third was transferred to the Infirmary with 'Erisepolas of the Knee'.[179] This may have been coincidence. However, seven deaths occurred Indoors between March and October 1859, almost twice the total for 1850, although no cause of death was recorded in the Birth Register. In addition three patients were transferred to the Infirmary. In 1860 there were again excessive deaths, six between June and December, the cause of only one being identified, as convulsions. There was then a fall to three deaths, including another from convulsions, in 1861. However, in 1862 there were six deaths and three transfers between February and June, the cause of one being identified as 'Puerperal Peritonitis'.[180] In 1863, following a case of erysipelas which was transferred to the Infirmary in November, there were two deaths in December, one identified as being the result of puerperal fever. This epidemic continued into 1864, and by the end of February there had been another seven deaths, all caused by puerperal fever, and two transfers to the Infirmary. At this point the directors closed the hospital to further admissions, and planned to clean and re-paint it once it was empty.[181]

It is evident from the comments of senior doctors in the Directors' Minutes that they saw the increase in puerperal infection in the late 1850s as a direct result of degeneration in the hospital environment, which they described as dirty and, especially, poorly ventilated. This they blamed on poor supervision by the matron, Mrs Johnston. In 1861 she attempted to resign, citing the 'infirmities of age'. Further enquiry by the directors revealed that it was more because she felt herself unfairly criticised by the doctors. However, 'Mr. Thomson [one of the lay directors] stated ... he had ... been in the practice of examining the Hospital ... it always appeared to him

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[178] 1850 OCB, case 3138 [274/3138/50so]. Gastric peritonitis was a euphemism for puerperal fever.
[179] ERMH Birth Register [BRERMH], Vol.1, pp. 117-18.
[180] Ibid. pp. 235-236.
[181] DMERMH, 12 February 1864.

to be kept in a fair state of cleanliness'.[182] In February 1862 Mrs Johnston complained to the directors of overcrowding, and was told to limit admissions to 24 except in emergencies. However, medical complaints about the condition of the hospital continued, and in 1863 Mrs Johnston did retire. Despite the appointment of a new matron, and the closure of 1864, fever deaths continued to occur. Following a further epidemic in 1869 the hospital was again closed and re-furbished, and plans were made to move to another building. However, it re-opened in the same premises in October 1869, having been 'thoroughly cleaned and rearranged to the satisfaction of the medical officers'.[183]

Within the hospital there were two deaths in 1870, both associated with infection. For example, on 21 January Dr Lambert was called to a house in East Arthur Place where he '[f]ound a child dead about 10 days in Utero, born 10 min when I arrived. Severe p.p.hem - Detached placenta - mother had puerperal mania Jan:23 and was admitted to Maternity Hospl. on 24th.'[184] She died a day later: presumably her mania was the delirium of systemic infection. However, it is apparent from the Special and Ordinary Casebook both that there was some understanding of antisepsis, and that complaints of ill-health by the patients were now taken seriously. The pulse rates of all patients were recorded twice daily. Pyrexia accompanied by feeling unwell was noted, and although not apparently measured, invariably treated. Ten patients were feverish during the postnatal period. In each case a cause was looked for and treated. Three were already sick with pulmonary tuberculosis, whilst one had been treated at the hospital previously for a breast abscess. Agnes Terry was '[s]ent to Infirmary with Scarlatina' three days after delivery,[185] thus removing a potential source of infection. However, four had apparently acquired infections in labour. All of these cases were given topical treatment, regular vaginal douches of either Condy's Fluid or carbolic solution, in addition to systemic anti-pyretics. Similar treatment was

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[182] DMERMH, 27 July 1861, 22 October 1861.
[183] DMERMH, 6 October 1869.
[184] 1870 OCB, case 596 [062/596/70fo].
[185] 1870 ICB, case 1749 [052/1749/70si].

given to an abortion case with a 'foetid discharge',[186] although she did not complain of illness.

The cases of infection reported in 1870 indicate how anxiety about the return of puerperal fever to the recently re-opened hospital encouraged increasing medical intrusion into the puerperium, although some of this impression may be the result of an increase in data available. The cases also demonstrate the contemporary application of antisepsis to childbirth. Carbolic was a treatment to be applied in the presence of, or strong suspicion of, infection, rather than a means to avoid it in the first place. However, Betsy Aitchison's breast abscess was recognised as a surgical case. It was 'opened antiseptically ... - Dressed with 2 layers of carbolated lac plaster', and had healed within a fortnight.[187]

During the 1870s anxiety about puerperal infection continued. However, it was no longer seen as the result of an unhealthy atmosphere in the hospital, but increasingly as the outcome of poorly applied antiseptic technique by attendants, in particular the nursing staff, which, with the exception of the matron, changed completely every three months. In 1879 the hospital moved to custom-built premises at 79, Lauriston Place. Disconcertingly, there was a rapid increase in infection cases, and in 1880 Halliday Croom introduced a strict antiseptic regime. In 1881 an additional post was created, that of Staff or Head Nurse, whose principal task was to ensure that the pupil midwifery nurses understood what was expected of them, particularly within the hospital. By 1890 one or two pupils accompanied medical students to almost all Outdoor deliveries, apparently to provide hygienic nursing care during and after delivery.[188] In 1890 this was very successful, as there were no infected cases recorded on the District.

Indoors in 1890 there were two infection cases. In February Janet Hunter was described as having 'Peritonitis during Puerperium' after a labour of over 33 hours. Both she and her baby were discharged well, and their case was not considered

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[186] 1870 ICB, case 1725 [028/1725/70si].
[187] 1870 ICB, case 1740 [043/1740/70si]; 1870 SOCB, pp. 48-9.

serious enough to merit an entry in the Special and Ordinary Casebook.[189] However, in April, Sarah Tracey was admitted in premature labour. 'She had no illness whilst carrying the child. As far as can be made out from her statement she never had any venereal disease.' The child was stillborn without interference, though the membranes were retained and removed manually. On her sixth puerperal day she was found to be pyrexial, although she 'did not complain of anything'. She was treated systemically with 'antipyrin' and liquid opium, and topically with a douche of 'corrosive sublimate solution'. However, her temperature remained high, and by day 10 she was vomiting and complaining of abdominal pain. She began to fit next day, and died that night. Post mortem examination revealed a massive abdominal and fallopian tube infection; the appearance of the infected matter was described in detail as supporting the final diagnosis of death from gonorrhoeal peritonitis. Both the post mortem report (as copied by the house surgeon) and the casebook account were at pains to stress that the uterus was clean, thus implying that the cause of her death was an earlier infection and not the result of hospital mismanagement.[190] This shows that the frequently iatrogenic nature of puerperal infection was recognised, if not willingly acknowledged.

By 1912 the observation of all patients for signs of infection had become routine. It is obvious from the Students' External Casebooks that the recording of temperature and pulse was a vital part of the students' daily visits to patients. When pyrexia was noted, it was acted on. Detailed study of the Leith Branch External Casebook shows that 29 of the 492 patients (6.1%) showed a rise in temperature at some stage of the puerperium, with four being discharged later than normal, although only one progressed to hospital treatment for salpingitis.[191] In eight of the pyrexia cases onset occurred on or before the third day, and in these the symptom, rather than the cause, was treated with aspirin and quinine by the pupil midwives. The majority of cases (18) happened on days 4-6, with six women sustaining a rise in temperature for more than 24 hours. All 18 were carefully investigated for breast engorgement or profuse

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[188] Pupil midwifery nurses attended 610 of the 666 Outdoor deliveries in 1890.
[189] 1890 ICB, case 3 DBH [029/3bh/90fi].
[190] 1890 ICB, case 53 DBH [079/53bh/90fi]; 1890 SOCB, pp. 69-71.
[191] 1912 SECB(LB), Case 289 [299/289/1912/Leith].

lochia, and most were treated topically, with enemata, douches, and castor oil, all treatments intended to encourage excretion of potentially infected matter and hence uterine involution. Aspirin and quinine were offered as anti-pyretics in only three cases, suggesting that a rise in temperature at this stage of the puerperium was so closely associated with reproductive tract infection that any case was to be treated as such until proved otherwise. Three cases occurred on the seventh day: all were treated with douching. No new cases developed later in the puerperium. In addition, one patient suffered from 'profuse & offensive Lochia' without ever having a rise in temperature. She was also treated topically.[192] Once a patient's health had been considered suspect by the pupil midwives, the decision to discharge was harder for pupils to take: four of the 29 pyrexial patients were ultimately discharged well by Sister Dewar. In contrast, only two of 463 non-pyrexial patients were discharged by her.

The management of Outdoor cases in Leith demonstrates well the influence of the fear of puerperal infection on the routine of the hospital by 1912. Anxieties about it led to the commitment to regular recording of vital signs by the most junior grade of professional staff, evidently with instruction to be cautious and to treat cases on the least suspicion of infection. Above all, it shows how fear of the basically untreatable puerperal fever encouraged the introduction of a medical approach to all childbirth.

Anxieties about infection are also evident in the handling of admitted cases in 1912, although there are no data extant equivalent to the routine recording of temperature and pulse in the Students' External casebooks. The only information available on infection within the hospital comes, with one exception, from those cases considered eligible for inclusion in the Special and Ordinary Casebook. However, with this as the source of information, approximately 9% of all Indoor patients were described as sick in some way in the postnatal period, and of these about 38% (22) were pyrexial, from a variety of causes. As in Leith, one case had signs of infection without

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[192] 1912 SECB(LB), Case 386 [397/386/1912/Leith].

developing a pyrexia, and was treated anyway,[193] whilst a second had a transient rise in temperature on her third day, which then and now would be ascribed to her milk coming in.[194]

The remaining 20 cases were more serious, and it should be noted that one-third of those women with recorded pyrexia (7) died from their infection. Five, including the erysipelas case, definitely brought infection with them from outside: one had tuberculosis, one meningitis, one pneumonia, whilst the last had concealed an obstructed labour until she was dying of septicaemia. On admission she was in 'profound shock … very ill ... cheeks hollow & eyes sunken … could be smelled as she entered the R.M.H'.[195] In the remaining cases the pyrexia appears to have resulted from the treatment they received in the ERMH. Two developed apparent deep venous thrombosis as a result of bedrest, whilst another had a chest infection following the use of chloroform. Two of the three cases whose invasive treatment was carried out in front of the clinique developed high temperatures in the puerperium: one woman was delivered by craniotomy, while labour was induced in the other whilst the head would still engage in the pelvis. A second induction of labour, this time for an intra-uterine death, took six days of inserting bougies and packing to achieve, by which time the patient was pyrexial, and complaining of '[h]eadache - slight pains - rapid pulse Bad taste in mouth'.[196]

Prolonged labour and tissue damage at delivery contributed to postnatal infection. For example, Mrs I was admitted after a 24-hour labour and failed forceps delivery by two doctors in her home: she was delivered by craniotomy by Haultain. She was severely shocked at delivery, and developed a fluctuating temperature and rapid pulse. A '[p]leural effusion due to cardiac weakness' was found, but in addition her 'abdomen [was] very much boarded & movement diminished'. She also had a 'blood count 16,000 leucocytons'. She was initially treated by curettage of the uterus '& swabbed with pure carbolic,' whilst '[a]ntistreptococcic serum 20cc. was injected

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[193] 'Pat had a strong smell - so vagina douched … making a excellent recovery ...' (1912 ICB, case 44 FWNH [44/044/hault/1912i]; 1912 SOCB, pp. 31-5.
[194] 1912 ICB, case 74 FWNH [74/074/hault/1912i]; 1912 SOCB, pp. 57-9.
[195] 1912 ICB, case 44 FWNH [24/024/hault/1912i]; 1912 SOCB, pp. 8-10.

every 24 hours', all with little effect. Pleural fluid was sent for culture but without result. A fortnight later 'Dr. Lackie again made exam under $CHCl_3$. Fluid made out in Pouch of Douglas - pus - (Blood count Polymorphs 85%). Pat[ient] sent up to ward 35 Dr. Barbour for oper'n'.[197] In addition, two patients died as a result of protracted labour, difficult delivery and infection.[198]

Whilst there was great anxiety about puerperal infection in 1912, there was also little contemporary attempt to make connections between the type of delivery and the occurrence of postnatal infection. It could be suggested that clinique cases especially, but also inductions for intra-uterine death, exposed the patients involved unnecessarily to risk. There is no evidence that ERMH doctors associated an apparent rise in infective cases in the hospital with the increase in emergency admissions, or with the treatment they had previously received. Once infection was suspected, treatment was partly symptomatic, partly intended to disinfect, but always vigorous, if ineffective. The records also suggest it was defensive in nature, and that the doctors were well aware that infection could expose their increasingly pro-active treatment as unsafe.

Puerperal infection occupies an almost contradictory position in the development of maternity care. There is little evidence in Britain that it influenced nineteenth and early-twentieth-century patients' decisions about their intended treatment, but, as has been shown, it has had profound influence on both historical thought and professional development. The ERMH data demonstrate clearly the changes in the medical understanding of puerperal infection. By 1890, in the new hospital building, it was seen to be the result not of an unhealthy environment, but, potentially, of a failure of duty by a birth attendant. This moral aspect of infection had implications for all hospital staff. Fear of infection can be seen to be a priority in the nursing management of the hospital and dispensary from 1880, and a major practical influence on both the midwifery training offered and midwifery's professional

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[196] 1912 ICB, case 34 FWNH [34/034/hault/1912i]; 1912 SOCB, pp. 17-18.
[197] 1912 ICB, case 43 FWNH [43/043/hault/1912i]; 1912 SOCB, pp. 29-30.
[198] See 1912 ICB, case 125 FWNH [125/125/hault/1912i], 1912 SOCB, pp. 97-101, and 1912 ICB, case 23 JHC [491/023/hc/1912i], 1912 SOCB, p. 202.

development. It provided a major impetus towards medicalisation of childbirth. However, it appears to have had less influence on medical practice, which became increasingly pro-active despite evidence of associated rises in infection.

4.6 Non-Quantifiable Treatment of Patients

Treatment of patients encompasses more than the physical care given at delivery, and includes the attitudes of staff. This is impossible to quantify, and, since the bulk of the evidence comes from the many authors of the Special and Ordinary Casebooks, its quality is difficult to assess. Nonetheless, it is possible to note a change in the attitude of the house surgeons towards the patients of the ERMH between 1870 and 1912. In general, descriptions of the physical appearance of patients in 1870 were limited to precisely that: Margaret Johnston was 'a strong healthy looking girl' whilst Amelia Simes was 'a very weak delicate-looking girl and has a decidedly anaemic appearance'.[199] When comments on lifestyle were made, they tended to be non-judgemental: Mary Miller 'was in service at Melrose, when labour set in and was at once sent off to the Maternity Hospital per rail'; Elizabeth Gair 'has led for some time a very irregular life and this is her second pregnancy'.[200]

By 1912 a patronising and unsympathetic tone had crept into many of the comments on patients. Dr Sivwright criticised Mrs U, whose general health was declining, for her failure to know her diagnosis: 'troubled a good deal with a cough & sweats a lot at night … As ... losing weight Dr Fraser sent her to see Dr Rainy at MOPD RIE. He examined her chest. Result unknown!'[201] Mrs P, dying from a '[l]arge haemorrhagic malignant ovarian tumour' was described as 'dull and uneducated, but lives in a clean country home', by Dr Ritchie.[202] Whilst the comments on Mrs G, an eclamptic admission from Millar Crescent, Morningside, who had intended to deliver at home attended by her doctor and a 'trained nurse', indicate some appreciation of patients'

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[199] 1870 SOCB, pp. 70, 50.
[200] 1870 SOCB, pp. 11, 80.
[201] 1912 SOCB, pp. 57-9.
[202] 1912 SOCB, pp. 137-9.

psychological state,[203] this courtesy was not extended to Mrs Ux, a miner's wife from South Queensferry. Two years previously she had had a horrendous delivery culminating in craniotomy by her GP, who now sent her to the ERMH as 'he does not care to repeat the experience'. Her state of mind was summarised briefly at the end of her physical examination: '[i]s very nervous'. Her failure to understand the ensuing treatment and stillbirth was considered risible: 'Note Pat[ient] thinks that Bougie killed the child - or if this did not - then packing in the vagina must have suffocated it!!'[204] Equally, the author seemed surprised that Mrs L, 26, with a history of '[h]abitual death of foetus in utero - & incidentally a contracted pelvis,' having been investigated for any '[h]istory of Syphilis', and having 'come up to RMH in order to have a live child if it is possible', appeared a '[n]eurotic type'.[205]

Whilst patients' home circumstances were sometimes the object of comment in 1870,[206] by 1912 they too could be judged, and their condition became part of the assessment of the patient. Mrs R, an 'Extern District Case' admitted from her home in the Canongate with postpartum eclampsia, 'seems better educated than her surroundings bespeak. House is clean and fresh air is advocated. Diet is simple & very little meat is taken',[207] whilst Mrs H was '[b]ecause of poverty brought into Hospital' after delivery by the dispensary.[208]

Chronologically this increasingly distant and critical approach to patients seems to coincide with the gradual conversion of the ERMH from a charity for the destitute pregnant, to one in which the primary interest of the medical staff was the management of the complications of pregnancy. It also coincided with an apparent divergence in the views of doctors and their patients about suitable treatment, which can be clearly seen in three main areas. The first, the decision to admit at all, has

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[203] 'Pat. has always been very healthy & athletic. Enjoys much fresh air & perhaps overdoes (!) golf as a sport. She is always jolly but with a tendency apparently to the neurotic type.' (1912 SOCB, pp. 90-2).
[204] 1912 SOCB, pp. 49-51.
[205] 1912 SOCB, pp. 84-6. This was her seventh pregnancy.
[206] Williamina Bain's room at Middleton's Entry, Potterow, was described as 'not ... so well ventilated as to enable one to give a prognosis at all favourable to the after conduct of the case'. (1870 SOCB, pp. 36-44).
[207] 1912 SOCB, pp. 66-8.

been discussed before, particularly in regard to Outdoor cases in 1890. However, even by 1912 some still looked at hospital admission askance. When Hannah R collapsed with a cerebral tumour, 'she was put to bed in the 'Boothy' & continued taking fits'. Her fellow potato-pickers called a doctor but 'his advice [to admit] was not heeded'. She was only admitted when he insisted and a closed cab and a nurse were sent.[209] The second area was that of method of delivery, clearly seen in the 1912 case of Annie L, a dressmaker, 'of very short stature - & small', admitted with a spontaneous rupture of membranes. She had 'no pains ... Dr Lackie wished to do a pubiotomy but Pat. refused ... Pat[ient] unmarried - & wd not consent to Op'n for live child'. She was delivered by craniotomy, 'performed by Dr Lackie in front of clinique'.[210] Her priorities were not his. Antenatal treatment could also be questioned: in 1912 Mrs G lost sympathy when, after two weeks of careful management of her hyperemesis gravidarum, she 'vomited during the night - allowed a poached egg and that was blamed but sister found that patient had demolished two large raw pears which had been smuggled into Hospital'.[211]

The third area in which a divergence between the medical and lay attitude can be seen is that of post-mortem operations or examinations. Although in 1850 Baby Davidson was delivered alive by 'Caesarian Section. Child at 8th month',[212] in 1890 Berry Hart was delayed in a similar operation as 'the husband hesitat[ed] to give his consent'. The baby failed to respond to artificial respiration.[213] A similar case occurred in 1912.[214] In addition, Janet W's baby was delivered stillborn after her death from eclampsia.[215] As the hospital became more involved with complicated and ultimately unsuccessful cases, patients' relations were increasingly faced with requests for post-mortem examinations. In 1890 there were four deaths in the hospital, and only one request for post-mortem was granted, whilst two were refused. By 1912 there were 27 deaths, and 15 requests for post-mortem examination were

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[208] 1912 ICB, case 28 JHC [496/028/hc/1912i].
[209] 1912 SOCB, pp. 234-9.
[210] 1912 SOCB, pp. 23-4.
[211] 1912 SOCB, pp. 220-4.
[212] 1850 ICB, case 2037 [072/2037/50fi].
[213] 1890 SOCB, p. 66.
[214] 1912 ICB, case 101 JHC [569/101/hc/1912i].
[215] 1912 SOCB, p. 190.

made, of which nine were granted outright, five were refused, and in a further case 'P.M. not granted wholely [sic] but small incision allowed'.[216] Post-mortem delivery or examination presented the patient's relations with a number of problems, of which the least was the care of a certainly weakened baby (only one is recorded as surviving these heroic deliveries). More disturbing was the opening of the dead body for scientific purposes, which, particularly in Edinburgh, must have had resonances of the trade in bodies for dissection of sixty years before. For the doctors, however, this represented an opportunity to extend their knowledge of the fatal event. The conflict between the two indicates that there was a limit to the medical treatment acceptable to the public. The small amount of evidence examined here suggests that the attitude of the house surgeons to their patients changed to become more judgmental over time. However, it also shows that patients and their families were not prepared to be passive, and to accept medical advice on treatment unquestioningly.

4.7 Conclusions

This chapter has examined in detail the changing nature of treatment offered to patients at the ERMH and its dispensaries from 1850 to 1912, and has observed the greater intrusion of the medical world into childbirth among the poor. It has also noted the increase in successful intervention by doctors in complicated childbirth, and therefore the need for better monitoring of labour. It has also provided evidence of the increasing recognition of the professional experience of the ERMH medical staff, especially by their fellow doctors, but also by patients. It has noted the greater use made of its pupil midwives by the hospital, to monitor labour, conduct delivery, and provide regular medical care to Outdoor patients.

During the period from the hospital's opening until the Great War, the treatment of childbirth and its complications changed considerably at the ERMH. It has been shown that there was a proportional increase in the number of cases of intervention at delivery by 1890, but also that this was not synchronous with the development of anaesthesia, whose use was seldom recorded at the hospital, nor directly with the

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[216] 1912 SOCB, p. 157.

introduction of antisepsis. Instead, it seems to be related to a move away from the conservative management of labour of the previous hundred years. This entailed a change of mindset on the part of the hospital's doctors, from the expectation that nature would overcome most problems, to one in which problems were looked for and corrected. This altered the hospital's expectations of its house surgeons. In 1870, 'the House Surgeon ... [was] not allowed to perform an obstetric operation on his own responsibility',[217] but by 1890 he was expected to be able to carry out forceps deliveries unaccompanied by a senior, and by 1912 podalic version had been added to his repertoire. A similar overall increase in intervention at this time in both Britain and America has been noted by Loudon.[218] The ERMH data confirms this observation, but in its new expectations of house surgeons also suggests an additional reason for it: that there was a greater standardisation of successful technique that made it possible for this knowledge to be shared with junior doctors. Acceptance of these protocols made possible a more formulaic approach to treatment.

The hospital material also shows changes in the treatment of childbirth in general. From 1870 there was increasing medical involvement in the minor ills of childbirth, in part the result of increasing professional anxiety about infection and mortality statistics. It can be seen particularly in the question of rest and mobilisation after childbirth, an area in which ultimately medical advice and the desire of middle-class reformers to improve the lot of working women combined to introduce major changes in the management of the puerperium in the twentieth century.

Changes in treatment also show the professionalisation of the staff. Increasing intervention illustrated the specialisation of obstetricians anxious to prove they were a separate branch of medicine.[219] The need for trained supervision in labour and the puerperium created a new role for attendants. Even uncomplicated childbirth became subject to medical involvement. At the ERMH the greatest change in treatment in the period studied was less the increasingly skilled intervention in major problems of childbirth, than the use of a low-grade professional group (supervised pupil

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[217] 1870 SOCB, p. 38.
[218] Loudon, *Death in Childbirth*, pp.183-4, 345-6.

midwives) to monitor parturient patients for problems, and, in the event of none, to care for them effectively in their own homes. Nonetheless, the hospital evidence, in particular the limited use of pain relief, indicates that its doctors continued to see childbirth primarily as a physiological process. The much greater use made of its pupil midwives by 1912 implies that in fact they relied on it to be so.

The increasing medicalisation of childbirth within the hospital's area of practice, gradually altered the attitude of its staff towards its patients, and that of the patients towards its staff. A more patronising tone towards the patients can be detected developing along with an increasingly pro-active practice, the implication being that medical knowledge of childbirth was now superior to that of the patients. Whilst the majority of patients appeared to accept their treatment, there were a series of minor clashes over intended methods of delivery, need for admission, time of mobilisation and discharge, and the need for post-mortem intervention, which suggest that the patients were not passive recipients. In about 1908 Margaret Milne Murray claimed that 'the poor married woman of Edinburgh prefers her wretched hovel and her empty cupboard to the comfort of a Lying-in Hospital' as a place for birth, and ascribed this to the deterrent effect of rumoured poor management and restrictive admissions policies at the hospital.[220] However, she may have been seeing continuing patient resistance to the idea of hospital admission and control. Nonetheless, patient influence was limited to electing to use the services of the ERMH, although their increasing use of the Dispensary indicates appreciation of the care offered.

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[219] See also Bashford, *Purity and Pollution*, pp. 63-6.
[220] Milne Murray, *The Practical Training in Midwifery of the Edinburgh Medical Student*, p. 10.

Chapter 5

The Provision of Midwifery Training and Experience to Medical Men and Nurses at the ERMH, 1844-1914

5.1 Introduction

This chapter analyses the data on ERMH staff, both permanent and pupils. As in Chapter 4, the data are derived principally from detailed analysis of all the Indoor and Outdoor cases in four discrete years, 1850, 1870, 1890 and 1912. The ERMH casebooks are unusual in that they contain the names of individual students. This makes possible both examination of the nature of the education offered to a large group of students, and the search for corroborative evidence. Additional biographical data has therefore been taken from the Medical Register and Directories, and Edinburgh University Calendars and Examination Schedules. The data relating to the experiences of both staff and pupils at deliveries has been analysed as described in Chapter 1, section 1.4.

The information derived from the above data can be used to examine three related themes at the ERMH. The first theme concerns the appearance patterns of staff. This chapter contends that staff patterns themselves (retrieved from casebook entries and compared with comments from the hospital management), indicate the changing nature of the hospital. This has not been much examined in other institutions: neither Quiroga (New York), nor McCalman (Melbourne) discusses the changing pattern of staffing. Whilst Quiroga notes the house-keeping role of the matron in New York's various lying-in institutions, and that at the Infants' Hospital trained nurses mediated between hospital board members and the medical world, and attending doctors were seen as an institution's servants, because she deals with a number of establishments she does not use staff as indicators of change.[1] In McCalman's case, she does not examine staffing patterns because she considers the Royal Women's Hospital

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[1] Virginia Anne Metaxas Quiroga, 'Poor Mothers and Babies: a Social History of Childbirth and Childcare Institutions in Nineteenth Century New York City' (State University of New York at Stony Brook, Ph.D. Thesis, 1984), pp. 37, 128-9, 47-78.

(although of similar age to the ERMH), always to have been primarily a source of medical treatment, rather than a social shelter.[2]

The second theme is that of male and female education in midwifery and this chapter addresses the evidence for this at the ERMH. There has been considerable writing on the development of the medical profession in the nineteenth century, and the role played by medical education in its professionalisation.[3] Bonner's recent overview of medical education in Europe and America between 1750 and 1945 has emphasised the degree of change that occurred in the nineteenth century.[4] As has been pointed out in Chapter 2, section 2.5.3, midwifery formed only a small and not always necessary part of that education. Nonetheless, it too was subject to change in the way that it was taught to medical students. Here the ERMH data seem only to illustrate the practical effects of the changes that occurred. They show the emphasis on practical skill, and the 'senior student' role of early house surgeons in the early period, with a contrasting emphasis on formal instruction in the later years, notably 1890.[5] The careers of selected medical students have been traced (as far as practicable), to examine whether was any relationship between the number of their appearances at the ERMH and their future medical lives.

Much less has been written on the education of midwives (as opposed to doctors), in Britain in the nineteenth century. As discussed in Chapter 2, section 2.5.5, this is partly because it has been over-shadowed by the registration debate, and its focus on particular skills and attitudes, and partly because trained midwives were in a minority in the profession until the inter-war years. However, McIntosh has examined the

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[2] Janet McCalman *Sex and Suffering – Women's Health and a Women's Hospital: The Royal Women's Hospital, Melbourne 1856-1996* (Melbourne: Melbourne University Press, 1998).
[3] See, for example, Lisa Rosner, 'Students and Apprentices: Medical Students at Edinburgh University 1760-1810' (Johns Hopkins University Ph.D. Thesis, 1985); Irvine Loudon *Medical Care and the General Practitioner 1750-1850* (Oxford: Clarendon Press, 1986); Charles Newman *The Evolution of Medical Education in the Nineteenth Century* (London: Oxford University Press, 1957); Ivan Waddington, 'General Practitioners and Consultants in Nineteenth-Century England: the Sociology of an Intra-Professional Conflict', in John Woodward and David Richards (eds) *Health Care and Popular Medicine in Nineteenth Century England* (London: Croom Helm, 1977); M. Jeanne Peterson *The Medical Profession in Mid-Victorian England* (Berkeley: University of California Press, 1978).
[4] Thomas Neville Bonner *Becoming a Physician: Medical Education in Great Britain, France, Germany, and the United States 1750-1945* (Oxford: Oxford University Press, 1995).

training offered by the Jessop Hospital for Women in Sheffield in the 1870s and after.[6] No training schedules or individuals' case records survive, but attendance at least 30 labours was required, and both she and Seligman (examining the Royal Maternity Charity), conclude that since the intention was for midwives to attend 'natural labours', teaching would have focused on when to call medical aid.[7] Again, the ERMH data provide additional illustration only, since in Edinburgh too no evidence for the content of doctors' lectures to midwives exists before 1910. However, the use of individuals' names in the casebooks does allow analysis of the experience of pupils, and that of female and male pupils can therefore be compared. Further, the ERMH data suggest that in 1870 in particular, pupil midwives had similar experience at the hospital to medical students. The chapter also examines the small amount of evidence for the future careers of ERMH-trained midwives, and suggests that they were assets to their communities.

The final theme is that of the professionalisation of obstetrics, and its development as a medical specialty in the late nineteenth and early twentieth centuries. This has been interpreted in a number of ways. McCalman, in her examination of the medical staff of the Royal Women's Hospital, Melbourne (founded 1856), has taken it for granted that from the hospital's beginning, its doctors were working in a recognised and respected medical field.[8] However, in his analysis of the development of general practice in England between 1750 and 1850, Loudon notes the poor status of midwifery among doctors, despite the skill of some practitioners, because of its rejection by both Royal Colleges,[9] and in *Death in Childbirth* he repeats his view that the professional development of obstetrics was obstructed until the late nineteenth

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[5] Ibid., p. 133: he is referring to London in the 1820s.
[6] Tania McIntosh, '"A Price Must Be Paid for Motherhood": the Experience of Maternity in Sheffield, 1879-1939' (Sheffield University Ph.D. Thesis, 1997); Tania McIntosh, 'Professional Skill or Domestic Duty? Midwifery in Sheffield, 1881-1936', *Social History of Medicine*, 11 (1998), pp. 403-20.
[7] McIntosh, 'Professional Skill or Domestic Duty?', p. 406; Stanley A. Seligman, 'The Royal Maternity Charity: the First Hundred Years', *Medical History*, 24 (1980), pp. 403-18.
[8] McCalman, *Sex and Suffering*, especially chapters 1 and 6, pp. 15-34, 93-115.
[9] Irvine Loudon, *Medical Care and the General Practitioner*, pp. 92-3, 174-5; Newman makes a similar point in *The Evolution of Medical Education*, pp. 161-2.

century.[10] In addition, he believes midwifery's exclusion from the main English teaching hospitals until the final quarter of the nineteenth century further reduced its status. However, he declares that this was not the case in Scotland, but does not elaborate. Nonetheless, in *The Tragedy of Childbed Fever* Loudon notes the profession's rapid establishment in the wake of the introduction of antisepsis to maternity hospitals, and its subsequent need for heroes, on a par with those in science and general medicine, which led to the 'canonisation' of Semmelweis.[11] Bashford has similarly linked the development of obstetrics with the application of antisepsis.[12]

Within the limited area of Edinburgh, the ERMH data do provide evidence of the development of obstetrics in Scotland. In particular, they show the expanding role and status of senior doctors in midwifery education and hospital life, but suggest this occurred principally in the final quarter of the nineteenth century and the early twentieth century. This chapter argues that increasing specialisation was more closely associated with the expanding educational role of senior staff, (itself the result of the growth in the medical schools), than directly with the use of antisepsis. Nonetheless the introduction of antisepsis did play a large role in the professional development of the female pupils at the ERMH. This chapter examines the increasing stratification of nursing and medical roles that occurred at the ERMH following the introduction of antisepsis, and argues that this provided midwifery nurses with a new medical role.

This chapter examines the three themes of changing staff patterns, male and female midwifery education, and the professionalisation of obstetrics, in the context of the ERMH. The general data for attendance at deliveries is examined first, and then the data for individual groups in each year is discussed. This approach allows the evidence for changes in professional roles to be seen in relation to each other, and

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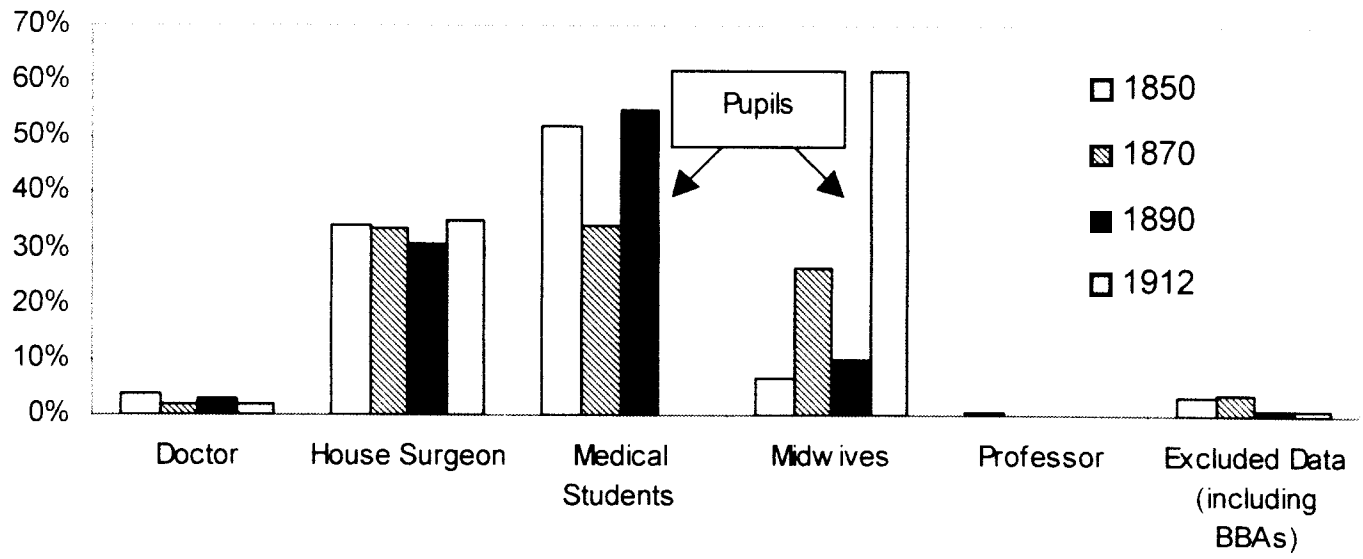
[10] Irvine Loudon *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality 1800-1950* (Oxford: Clarendon Press, 1992), pp. 188-93.
[11] Irvine Loudon *The Tragedy of Childbed Fever,* (Oxford: Oxford University Press, 2000). pp.145-50.
[12] Alison Bashford *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (London: Macmillan Press Ltd., 1998), pp. 63-83.

not in isolation. The chapter argues that the changing staff patterns, particularly among the nurses, indicate both the increasing medicalisation of normal childbirth when attended by the ERMH, and the hospital's gradual change from a shelter to a place of treatment. This can also be seen in the changing role, and attitude to the hospital, of its senior doctors. The chapter illustrates both the variation that occurred in the practical midwifery experience of medical students, and the continued existence (and some of the content) of midwifery training in Scotland. Finally, the chapter argues that, after 1870, visible differentiation occurred in the skill and knowledge required by the three junior groups at the hospital. This led to increasing stratification among the caring groups and increasing definition of the roles of the attendant professionals.

5.2 General Data Relating to Students and Staff at the Edinburgh Royal Maternity Hospital

The dependence of the ERMH on its pupils is clearly seen in Figure 5.1.

Figure 5.1
Status of Personnel Recorded as Carrying out Deliveries at the ERMH (in percentages), 1850-1912



Source: ERMH Indoor and Outdoor Casebooks, 1850, 1870, 1890, 1912

Throughout the period studied, the honorary staff, including the professor, delivered fewer than 5% of all cases, the great majority being delivered by fee-paying pupils. When, as has been shown in Chapter 4, section 4.2, the degree of intervention at

delivery increased between 1870 and 1890, new skills were taught to the house surgeon, and the percentage of cases falling to senior doctors remained stable. Even the introduction in 1884 of an additional senior post, that of assistant physician, did not affect this pattern. The percentage of cases apparently delivered by the house surgeons also varied little, being around a third. Most fluctuation can be seen in the recorded deliveries by medical students and pupil midwives. In both 1850 and 1890, medical students carried out over 50% of deliveries. In the earlier year, this was the work of 38 students, who attended 443 deliveries. In 1890, 180 medical students attended 526 deliveries. The high number of students shows the popularity of the Edinburgh Medical Schools at that time. Medical students' names are completely absent from the record in 1912. Due to recent organisational changes, described in Chapter 2, section 2.5.3, they now spent their practical training with the 'associated' dispensaries, which were under the influence of the ERMH, but whose casebooks have not survived.

The percentage of deliveries attended by female pupils[13] varied inversely with those of medical students. In 1870, when there were only 28 medical students, the 25 nurses carried out 27% of all deliveries:[14] by 1890 this had fallen to 10%. However, in 1912 they are recorded as having carried out all Outdoor normal deliveries, approximately 61% of the total deliveries of the hospital.[15]

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[13] In 1850 they were called midwives; in 1870 and 1890 they were called nurses, whilst on their certificates they were called midwifery nurses. By 1912 they were called nurses, but took the qualifying examination of the Central Midwives Board for England and Wales, and in 1916 applied for enrolment with the Central Midwives Board for Scotland by reason of their ERMH certificates.
[14] The medical students delivered 35% of all cases.
[15] By that year the hospital provided attendants to 21% of deliveries in Edinburgh (and 65% of charitable ones), and ran a second dispensary in Leith. The associated dispensaries were responsible for 13% of Edinburgh births.

5.3 Evidence from 1850

5.3.1 Senior Doctors

In 1850 eight senior doctors appear in the casebooks.[16] This includes Dr Thatcher of the Edinburgh Lying-In Institution (see Chapter 2, section 2.3.3), who attended one emergency in High School Yards, close to the Institution in Niddry Street, as '[t]here was considerable haemorrhage'.[17] The remaining seven doctors all had other traceable connections with the ERMH at the time. They carried out 13 deliveries, and witnessed a further 11. Simpson and Thomson[18] were most active, attending six cases each, whilst Ziegler only carried out one delivery. On three occasions they consulted before delivering a difficult case. The doctors were not confined to individual periods in the year; Keiller, for example, attending cases in February, August, and November, whilst Simpson saw cases in February, July, August and December. The casebook data confirms the impression from other sources that the ERMH took only a small number of problem cases, to handle which the senior doctors sometimes needed moral support or confirmation of their decisions by their peers, and that doctors' attendance was infrequent and random.

The data also provide supporting evidence of teaching. Keiller carried out four deliveries. On each occasion he was accompanied by the house surgeon, and twice by male and female students. Given his reputation as a teacher of midwifery, it is reasonable to assume that he was using these cases to teach. In two of Simpson's cases, he was undoubtedly teaching the attendant house surgeon. However, he is recorded as attending the remaining cases alone, and one, almost certainly a private case, may have required particular discretion.[19] However, other seniors with no lasting reputation for teaching were also witnessed carrying out complicated deliveries, and on two occasions supervised the house surgeon delivering by forceps.

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[16] This excludes Dr Cameron. He attended fourteen normal deliveries Outdoors in three weeks, then disappeared from the record. He cannot be identified from either Medical Directories or the Register. It is possible he was a special pupil.

[17] 1850 Outdoor Casebook [OCB], case 3008 [030/3008/50fo]. The others were Drs Simpson, Thomson, Keiller, Cumming, Weir, Moir and Ziegler.

[18] Alexander Thomson was a graduate of St. Andrews, and described as physician to the ERMH in 1861. He regularly attended the ERMH Dispensary for Women and Children 1847-8.

The implications of the casebook data regarding senior doctors in 1850 are that their role in the hospital, Indoor and Outdoor, was minor, and compatible with the interpretation that it was primarily a charity. Even the teachers appeared seldom, and at random intervals, when required.

5.3.2 House Surgeons

In 1850 four pairs of house surgeons worked at the ERMH, of whom J. Urquhart remains completely untraced. They had varied educational backgrounds and origins.[20] Cunningham and Sherlock graduated M.D. and M.R.C.S.E. in 1849. Landell matriculated for the last time in 1849. However, he does not appear in the 1850 Examinations record, and is recorded as 'Mr. John Landell'.[21] George Harley, aged 21, took his final M.D. and M.R.C.S.E. examinations whilst in post in summer 1850.[22] George Jobling matriculated again in 1851, and took his M.D. from St. Andrews in 1854. Exceptionally, William Wentworth Heude had matriculated for the last time in 1841. At the time of the 1851 census, he was 31, and described as 'Res. M.D., L.R.C.S. Edin.'[23] Thus, with the exception of Heude, in 1850 the house surgeons were young men, senior medical students, or on the point of qualifying.

The house surgeons' hospital experiences can be seen in Figure 5.2, in the order in which they appear. Unusually, Landell elected to return for a second stint. It should be noted that in this year the quarters for which they were engaged ran from the beginning of February to the end of April, May-July, August-October, and November-January. Thus only the final month of Cunningham and Sherlock's experience, and the first two months of Heude and Landell's, are included in the data.

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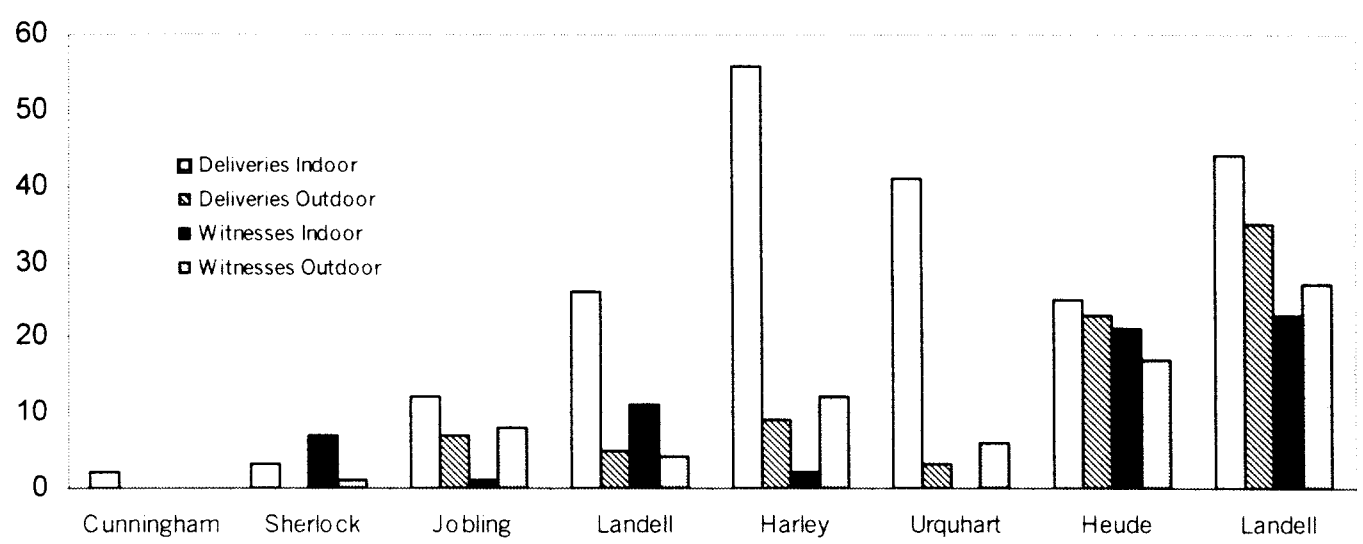
[19] 1850 Indoor Casebook [ICB], case 1190 [025/1190/50fi].
[20] Information on the careers of house surgeons and medical students comes first from the Comrie files, compiled from the Matriculation records of the University of Edinburgh (Special Collections, Edinburgh University Library), and from the Medical Register (after 1859), and Medical Directories (after 1856).
[21] For example, 1850 ICB, case 1174 [009/1174/50fi]. Born in Brazil, he may have returned abroad.
[22] 1850 Medical Examinations: Harley, p. 140.
[23] N. R. and S. Carstairs (compilers) *Edinburgh 1851 Census*, Volume I, *The Canongate*, (Scottish Genealogy Society, 1993), p. 279.

From Figure 5.2 it can be seen that there was wide variation in the number of cases delivered and witnessed by the different house surgeons, but that this cannot necessarily be explained by one of the pair predominating in one area: both Harley and Urquhart had a large number of Indoor deliveries, but a small number of Outdoor cases. All the house surgeons witnessed a much smaller number of cases than they delivered. These represented a number of scenarios, as can be seen in Table 5.1.

Figure 5.2
Numbers of Deliveries Carried Out and Witnessed by House Surgeons at the ERMH, Indoors and Outdoors, 1850



Source: ERMH Indoor and Outdoor casebooks, 1850

Table 5.1
Number and Type of House Surgeons' Experiences at the ERMH, 1850

	Indoor	Outdoor	Total
Total House Surgeon Deliveries	209	83	292
Total Deliveries Accompanied by Senior	2	4	6
Total Deliveries Accompanied by Male or Female Pupil(s)	12	5	17
Total Cases Witnessed (includes duplicate cases) [a]	65	75	140
Total Cases where Witnessed Delivery by Senior (includes duplicate cases) [a]	2	9	11
Total Cases where Witnessed Delivery by Male or Female Pupil	24	44	68

Source: ERMH Indoor and Outdoor casebooks, 1850

[a] That is, cases witnessed by more than one house surgeon.

In six cases the house surgeon delivered, but was accompanied by a senior doctor or the professor. In five of these there was a known problem, and two were delivered by

forceps, and two by version. In the final case support was required as the 'patient is hunchbacked and pelvis slightly deformed the head came out in the IV position a loop of cord born with head and several coils beneath the chin. Prest. Dr. Simpson'.[24] All these cases show instruction in abnormal delivery occurred, as do the 11 occasions where the house surgeons witnessed their seniors in action. Of these, seven cases were forceps deliveries, and one was a breech presentation. Thus a determined attempt was made to teach house surgeons with the limited obstetric material available. As will be shown, this contrasts with the treatment of medical students: house surgeons were evidently seen as superior pupils, treatment which is compatible with the larger fees they paid (see Chapter 2, Section 2.5.2).

In 17 cases the house surgeon himself was teaching, these being mainly Indoor cases where he delivered accompanied by one to three pupils.[25] The majority of these cases were unremarkable. In 68 cases he witnessed normal deliveries by his pupils, male and female. However, on 44 occasions he witnessed deliveries Outdoors, and these were more likely to indicate that he had been summoned to help. For example, in seven cases there was a delivery problem, including twins, breech presentation, long labour and a patient who, '[b]efore labour and during it, was affected with dimness of sight'.[26] In six cases there was a problem with the third stage. However, in 10 breech presentations Outdoors, the house surgeon was not present, and nor was he for two twin deliveries. He also appears not to have been summoned in a further 10 cases of retained placenta or post-partum haemorrhage. Thus on 13 occasions when there was a perceived problem at delivery, the house surgeon was present, but at a further 22 similar occasions, all delivered by medical students, he was not. Although the house surgeon did apparently provide some instruction or demonstration, especially to midwives, it is apparent that in 1850 the house surgeon provided little support to the male pupils when their cases deviated from the norm, or superior care to the Outdoor patients.

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[24] 1850 OCB, case 3432 [009/3432/50so].
[25] Three was the maximum number stipulated by the Rules (*Rules and Bye-Laws of the Edinburgh Maternity Hospital* (Edinburgh: Andrew Murray, Printer, Milne Square, n.d.), 'House Surgeons', Rule 3). In only one case was this exceeded, by one. (1850 ICB, case 1181 [016/1181/50fi]).

On average the house surgeons of 1850 attended approximately 70 cases each during their time at the ERMH. The use they made in their future careers of their midwifery experience is unclear. Heude and Landell do not appear in the Medical Register. In 1860, Heude's address was given as the 'East India U. S. Club, London SW', indicating that he returned abroad.[27] Cunningham became an army surgeon, whilst James Sherlock was by 1861 Medical Superintendent of the County and City of Worcester Pauper Lunatic Asylum. However, George Harley took a house physicianship at the Royal Infirmary, and then moved south, holding a variety of posts at University College Hospital, and ending as Professor of Medical Jurisprudence. In 1854 he wrote a paper on the changes in blood and urine in pregnancy and he was also a member of the London Obstetrical Society. However, his interest in parturition waned, as his later papers dealt with the male genito-urinary system, and the development of liver disease. George Jobling apparently made best use of his midwifery experience at the ERMH. He returned to Northumberland, his home county, and by 1856 was Medical Officer to Morpeth Union, and in general practice in Morpeth.[28]

5.3.3 Medical Students

The casebooks for 1850 record the names of 38 medical students who attended the ERMH for the practical midwifery component of their course. Of these, 31 were matriculated students, two became members of the College of Surgeons of Edinburgh, and were presumably from the extra-mural school, and five were untraced. They had a wide range of experiences, from one to 59. Figure 5.3 shows their experience as a cumulative graph. This shows that eight students accounted for half of the total experiences of the whole group. The careers and ERMH experience of the eight, and those of five 'low scorers' whose experiences totalled more than one, and were not at either end of the year, have been examined in more detail, to see if there were any differences between the two groups.

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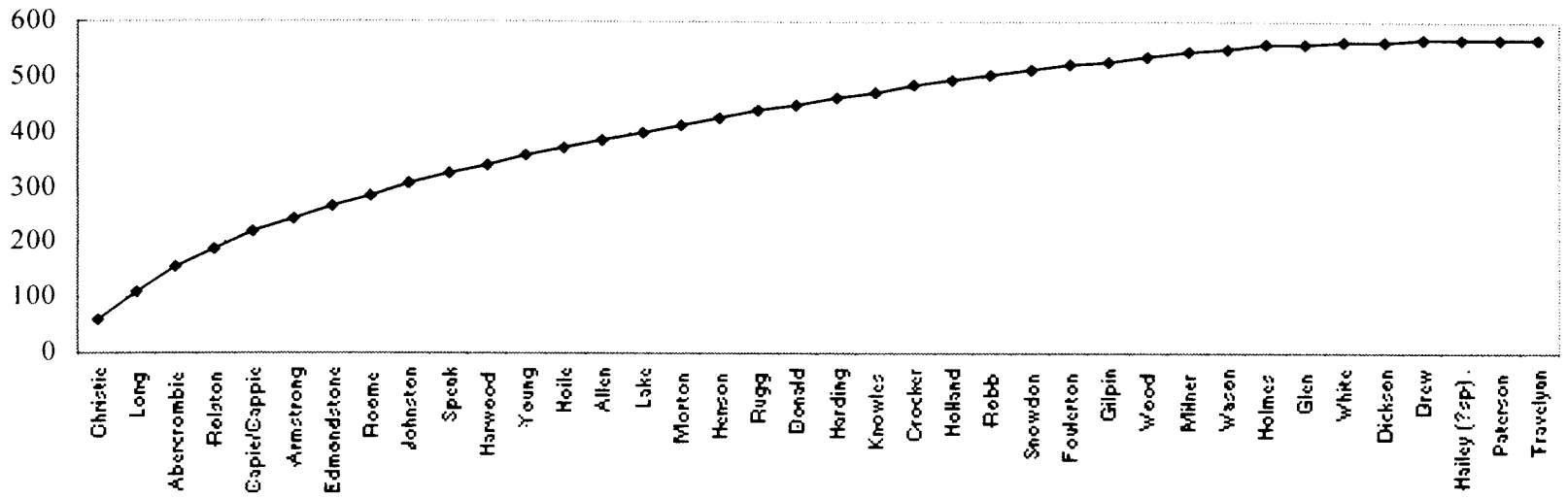
[26] 1850 OCB, case 3035 [053/3035/50fo].
[27] *Edinburgh University Calendar*, 1860-1 (Edinburgh: Thos. Constable, 1860), p. 274.

Figure 5.3
Cumulative (Pareto) Graph of the Experiences of Medical Students attending the ERMH in 1850



Source: ERMH Indoor and Outdoor casebooks, 1850

Table 5.2
ERMH Medical Students Selected for Further Examination, 1850

Name	Number of Experiences	Career
Christie	59	General practice
Long	50	Navy
Abercrombie	45	General practice
Rolston	35	General practice
Cappie	29	General practice
Armstrong	25	General practice
Edmondstone	22	Not traced
Roome	20	Indian Army
Foulerton	8	Private means?
Milner	7	General practice
Wason	7	Not traced
Holmes	6	General practice
White	3	Army

Source: ERMH Indoor and Outdoor casebooks, 1850; Medical Register and Directories

In each group, one student was untraced. Four students of the 13 declared where they had had their practical midwifery experience on their final examination schedules, and in each case it was through the Maternity Hospital only. Three of these were in the 'high' group: the ERMH evidently provided keen students with copious

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[28] *The London and Provincial Medical Directory, inclusive of the Medical Directory for Scotland, and the Medical Directory for Ireland, and the General Medical Register* (London: J. and A. Churchill), [LPMD] for the years 1853, 1860, 1865, 1870, 1872, 1874, 1880, 1885, 1890, 1896.

experience. Ebenezer Milner, who had seven experiences and is in the 'low' group, had been apprenticed to I. Milner of Leith, and may have had additional midwifery experience through this, especially as he had attended Hamilton's lectures 14 years before, in 1836-7. Eight students similarly declared their midwifery lecture course, all attending Simpson's 1849-50 lectures.

The careers of the 11 before they entered the ERMH are very similar, both to each other, and to those of the house surgeons. All bar Milner, who was 31, were aged between 20 and 28, the majority being 22. Nine would take their M.D. in 1850, at the same time as Harley, whilst two qualified in 1851. Nine combined this with examination for membership of the Royal College of Surgeons of Edinburgh in the same year.

Whilst they were attached to the hospital, the medical students worked principally Outdoors: only 6% of their experiences were Indoors, and approximately half of these were witnessing others deliver, usually the house surgeon. The experience of all the medical students can be seen in Table 5.3.

Table 5.3
Number and Type of Medical Students' Experiences at the ERMH, 1850

	Indoor	Outdoor	Total
Total Medical Student Deliveries	17	426	443
Total Cases Witnessed (includes duplicate cases) [α]	15	110	125
Total Deliveries Accompanied by Senior	7	30	37
Total Cases where Witnessed Delivery by Senior (includes duplicate cases) [α]	11	10	21

Source: ERMH Indoor and Outdoor casebooks, 1850

[α] That is, cases witnessed by more than one medical student.

This shows medical students only witnessed a small proportion of the cases they attended, and in fact they carried out 308 deliveries on their own. Thus they had limited opportunity to learn by watching another practitioner. Further, only six of the 21 instances where they did do so, gave them experience of the abnormal. In one case, Henry Crocker watched whilst '[t]he child was turned by Dr. Harley in the

presence of Dr. Simpson – Chloroform',[29] and on five other occasions students were able to see Keiller or Thomson deliver by forceps or version. On 11 occasions there were problems at a medical student delivery at which a more senior doctor was present: five of these involved third stage problems, with the implication that help was only sought after delivery. Thus there was minimal practical teaching of medical students as a whole in either normal or abnormal cases, although they were able to gain a great deal of experience. This lack of instruction is the greatest difference between the medical students and the house surgeons.

However, individual medical students did receive instruction from the house surgeon: James Abercrombie, aged 20, from the Cape of Good Hope, witnessed a normal and a breech delivery by Landell within the hospital, before delivering a case of his own Indoors. He attended 35 deliveries unsupervised, and had 45 experiences in total. Elizabeth Garrett Anderson attended the ERMH as a pupil of Keiller in 1863, and left a description of the supervision of her first two deliveries there. She attended 12 cases in total, and unusually, 'witnessed upward of a hundred'.[30] However, whilst James Christie, 22, from Londonderry, was supervised at his first delivery, he was not thereafter, and though he witnessed other students in action, he never saw any person senior to himself deliver. His colleague, James Long, also 22 and from Londonderry, with whom Christie attended 45 cases, had no recorded supervision or instruction. Perhaps less surprisingly, Milner delivered his seven cases unsupervised.

Unlike the house surgeons, the medical students needed their midwifery experience before they could enter their final M.D. examinations, and thus the copious experience they had at the ERMH could be tangential to their future careers. The high number of cases they delivered, on average 12 each, could have resulted less from their enthusiasm than from a high number of applications to the hospital from poor women, whom they were committed to attend on pain of ignominious dismissal. However, the future careers of the selected medical students suggest that for the

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[29] 1850 OCB, case 3407 [216/3407/50so].
[30] Jo Manton *Elizabeth Garrett Anderson* (London: Methuen & Co., 1965), pp. 143-5.

majority, their midwifery experience was of use in later life. There is little distinction between those with high and low scores. Of the seven traced in the 'high' group, two joined the services, whilst the others apparently went into general practice, where they would have been well-equipped to attend deliveries.[31] James Cappie, who had delivered 29 cases, remained in Edinburgh, based in Lauriston Place. In the 1860s and 70s he contributed papers on puerperal convulsions, placental abruption, and the use of forceps to the *Edinburgh Medical Journal*, suggesting he retained an active interest in childbirth. However, he was not a member of the Edinburgh Obstetrical Society, membership of which was confined to doctors actively engaged in midwifery, and in 1868 he provided dispensary, not midwifery, experience for Alexander Gordon.[32] In the 'low' group, one joined the army and three went into general practice.

The casebook data and the biographical information for the medical students, when available, indicate that they conformed well to the requirements made of them in the hospital rules, and that they easily achieved their necessary cases. They had copious practical midwifery experience at the ERMH, which equipped them well for general practice. However, the focus was on gaining practical skills, and they had little experience of problem cases. Further, in contrast to the treatment of house surgeons, there was little apparent attempt to show them the cases that were available.

5.3.4 Midwives

In 1850, 25 women's names appear in the Indoor and Outdoor casebooks.[33] Of these, only four (Mrs Rogers, matron at the beginning of the year, Mrs Johnstone, matron at the end of the year, Mrs Kerr and Mrs Wooly), are not described as 'midwife' at some point in the record. The pattern of their appearances (Figure 5.4) suggests that most were pupils. They attended for a short period of time, usually much less than three months, and then left, and for much of their experience they were accompanied

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[31] LPMD, 1853, 1860, 1865, 1870, 1872, 1874, 1880, 1885, 1890, 1896, 1901.
[32] 1870 Medical Examinations: Gordon.
[33] Significantly, this number is consistent with Hamilton's claim in 1818 that a thousand midwives had been trained in Edinburgh in the previous 40 years; that is, 25 a year. (Jean Donnison *Midwives and Medical Men: a History of the Struggle for the Control of Childbirth* (London: Historical Publications (2nd edn), 1988), p. 50).

by the house surgeon, either watching him deliver, or being observed themselves (Table 5.4).

Figure 5.4
Appearances of the Midwives at the ERMH, by Week, 1850

Maxwell	******. . . . .
Dunn	. . *******. . . . .
Gunn	. . *. . . . . *. . . . .
Hardy	. . . ***. . . . .
Rogers	. . . *. *. . . . .
Anderson	. . . . . *. . . . .
McMichiel	. . . . . *. . . . .
Watson	. . . . . *. . . . .
Reid	. . . . . *. *. . . . .
Aird	. . . . . *. . . . .
Lamb	. . . . . *. . . . .
Clark	. . . . . *. . . . . *. . . . .
Chisholm	. . . . . ***. . . . .
Hutchinson	. . . . . ***. . . . .
Tyrie	. . . . . *. . *. . *. . . . .
Fleet	. . . . . *. . . . . *. . . . .
Wooly	. . . . . *. . . . .
Hutchison	. . . . . **. . . . .
Robertson	. . . . . **. . . . .
Kerr	. . . . . ***. . **. ***. . . .
Richardson	. . . . . **********.
Johnstone	. . . . . *. . . . . *
McDonald	. . . . . **. *. . . . .
Johnston	. . . . . *. . . . .
Ross	. . . . . *. *
'& co.'	. . . . *. . . . .

Source: ERMH Indoor and Outdoor casebooks, 1850
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

Table 5.4
Number and Type of Midwives' Experiences at the ERMH, 1850

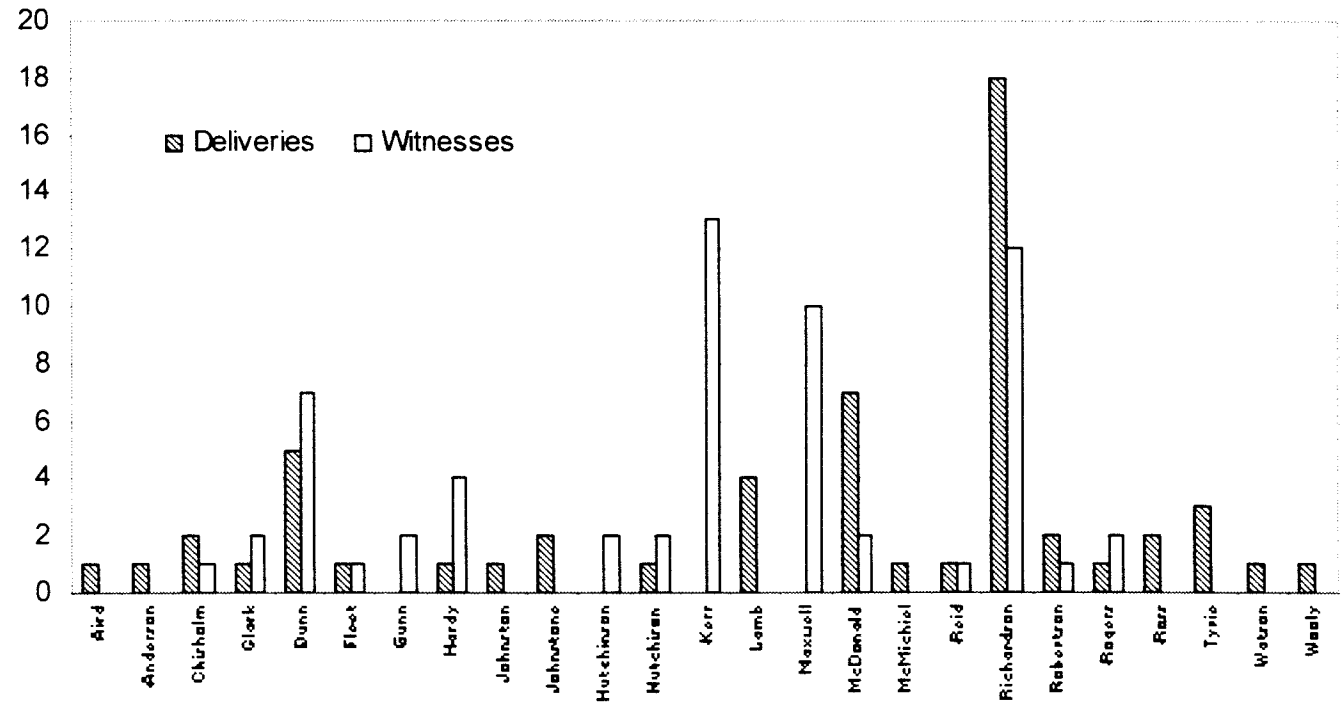
	Indoor	Outdoor	Total
Total Midwife Deliveries	31	26	57
Total Cases Witnessed (includes duplicate cases) [α]	47	16	63
Total Deliveries Accompanied by Senior	11	5	16
Total Cases where Witnessed Delivery by Senior (includes duplicate cases) [α]	34	10	44

Source: ERMH Indoor and Outdoor casebooks, 1850

[α] That is, cases witnessed by more than one midwife.

Individually there was wide variation in the number of midwives' experiences (Figure 5.5).

Figure 5.5
Numbers of Deliveries Carried Out and Witnessed by Individual Midwives at the ERMH, 1850



Source: ERMH Indoor and Outdoor casebooks, 1850

Twenty of the women had less than six experiences, whilst the remainder had between nine and 30. Six had only one delivery experience. Those who attended a large number of cases received both Indoor and Outdoor experience, and were more likely to see obstetric complications, although the combination of the current approach to midwifery, and the reasons for which the patients chose ERMH care, ensured that these were few. Five midwives saw breech deliveries by the house surgeons within the hospital, and two delivered breech presentations themselves

Outdoors. On three occasions midwives witnessed forceps deliveries by senior doctors. In addition, three saw tedious labours, and three the management of ante-partum haemorrhage. Thus the majority of midwives who passed through the hospital in 1850 had very little practical experience there, and minimal practical training in the management of obstetrical emergencies. Nor were the midwives expected to nurse patients:

> it was not the practice of the house ... [it] was unnecessary as in every ward several undelivered patients slept during the night whose duty it was to attend to the requirements of the delivered patients and to call the House Surgeon ... where his assistance was required.[34]

The evidence for the type of woman who attended is scanty. The 1851 census records three female staff members; Mrs Johnstone, the matron and wife to the chaplain, aged 54; Nurse Mary Gray, a widow of 63, and Mrs Barbara McGregor, a widow aged 28. Three other women, whose careers have been researched by Barbara Mortimer, Mrs Balmer and Mrs Dearness, both from Edinburgh, and Mrs Bethune of Lower Largo, also attended in this period. Mrs Balmer was 32, and possibly newly-widowed when she attended. Mrs Bethune was already widowed. However, Mr. Dearness was still alive when his 49-year-old wife attended.[35] Overall, this evidence suggests that midwifery was an occupation for widowed women in need of financial support, taken up in the middle years of life.

The evidence that survives of the careers of ERMH-trained midwives from the years around 1850 suggests that they made good use of their investment in their profession, and were well-respected. Mrs Margaret Robertson was a pupil in 1848 before working in Arbroath. When she emigrated to New Zealand in 1863, she took with her a testimonial from the local doctor, G. W. Wannan, himself an Edinburgh graduate: 'I have had occasion to meet her occasionally in a professional way. From what I know of her ... she is worthy of confidence and do recommend her

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[34] ERMH Directors' Minutes [DMERMH], 6 December 1862.
[35] Barbara Mortimer, 'Independent Women: Domiciliary Nurses in Mid-Nineteenth Century Edinburgh', in Anne Marie Rafferty, Jane Robinson, and Ruth Elkan (eds) *Nursing History and the Politics of Welfare* (London: Routledge, 1997), pp. 133-49.

accordingly.'[36] Mrs Bethune was similarly respected by her local doctor, and practised successfully in her home area for many years.[37] However, Mrs Balmer and Mrs Dearness, whilst called 'midwife' in the casebooks, advertised themselves as ladies' nurses and apparently only worked as such. Mortimer feels they relied on the contacts they made with doctors when at the hospital for recommendations to potential employers. However, to work as a ladies' nurse did not preclude work as a midwife: Mrs Barbara McGregor, resident in the hospital on census night, 1851, described herself as a 'midwife and ladies' nurse'.[38] The scanty casebook data and the biographical information for the midwives indicate that they continued to conform both to the eighteenth-century image of their occupation, and to the hospital's requirements.

The experiences of the hospital staff in 1850 illustrate three related themes in the development of the hospital. Firstly, the hospital had little organisational structure, calling upon its honorary physicians randomly, as necessary. There was no real distinction between house surgeons and medical students in education or experience: any difference lay in being prepared to invest more money in a study of midwifery. The midwives had no nursing function: ante-natal patients cared for their fellows. Secondly, whilst the senior doctors shared their knowledge, particularly with the house surgeons, the medical students and midwives were offered a great deal of experience, but apparently very little instruction, particularly in the management of problems in labour and delivery. Thirdly, the study of midwifery was still at the stage of observation, rather than action, whilst the care of the newly-delivered was evidently seen as not medical, but social. The consultations between the senior doctors when intervention was required suggest timidity when faced with the abnormal, whilst the similarity between house surgeon and students, and the failure to use the house surgeon as a resource when problems arose, suggest an expectation that all cases would deliver normally.

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[36] Testimonial of Mrs Margaret Robertson, included in her papers. [Lothian Health Services Archive [LHSA], LHB MAC GD 1/27/1-3].
[37] Barbara E. Mortimer, The Nurse in Edinburgh c.1760-1860: The Impact of Commerce and Professionalisation (Ph.D. thesis, University of Edinburgh, 2002), pp. 199-220.

In summary, the experience and training provided for the three groups at the ERMH in 1850 placed most emphasis on the normal and practical. It was geared to giving the pupils a solid practical skill that they could use in their future careers, harking back to the eighteenth-century selection of courses by Edinburgh students, as described by Rosner, rather than forward to the completion of a defined medical syllabus, as required by 1890. Despite Simpson's innovations in pain relief, and his international reputation as an obstetrician, in 1850 the hospital with which he was associated and at which many of his pupils gained their practical experience, still offered its trainees an experience not dissimilar to that which their fathers would have had.

5.4 Evidence from 1870

5.4.1 Senior Doctors

Five senior doctors, including the two Professors Simpson, are recorded in the casebooks for 1870. In various capacities, they attended 23 cases in the year, including all instrumental or complicated ones. Charles Bell was the most frequently recorded, attending nine cases in total. The elder Simpson attended one case before his death in May; Alexander Simpson and William Ziegler attended three each.

In four of Bell's cases he delivered by forceps, being accompanied by the house surgeon in three, and presumably teaching by example. In three of the cases he witnessed, he was supervising the house surgeon delivering with forceps, whilst in two he was supporting one of his senior colleagues, and perhaps learning from his management of a complicated delivery. Whether through chance, inexperience or preference, Bell employed forceps only, although he was present when Keiller delivered by version. His cases were spread throughout the year, and divided between Indoor and Outdoor. Thus, as in 1850, there was apparent teaching by practitioners who did not hold lecturing posts.

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[38] Carstairs, *Edinburgh 1851 Census*, Volume I, *The Canongate,* p. 279.

Keiller, who did have both a reputation for teaching and a lecturing post, attended six cases, all Indoors. In recognition of his great experience, he attended the majority of complicated cases requiring more than a forceps delivery.[39] On one of the two occasions when he witnessed a delivery, he was supervising a house surgeon; on the other he appears to have been giving moral support to Bell. Again, his cases were distributed over the year. He may also have had private pupils at the hospital. Archibald Bleloch described himself as Keiller's rather than the hospital's pupil for his practical midwifery, and listed 14 cases at the ERMH on his examination schedule. The casebooks confirm that he delivered 14 women Outdoors between 21 March and 23 May 1870.[40]

As in 1850, the casebook data confirms that the involvement of the senior doctors was largely limited to attendance on abnormal cases. Again, they were not limited to a particular period of the year, with a distancing effect on their relations with the house surgeons and the hospital. However, they can again be shown to be making a small contribution to the practical educational purpose of the hospital.

5.4.2 House Surgeons

In 1870, four pairs of house surgeons worked at the ERMH, of whom two, William Williams and E. Lambert, remain untraced. They were more varied in their medical education and background than their predecessors in 1850. Somerville was 34, and thus older than the others. He described himself as M.R.C.S.E. (1858) in the Medical Register of 1859, and in the casebooks as 'Somerville R. J., M.D. (USA)'.[41] Josiah Walker had taken the old M.D. as his first degree in 1869, whilst Ezekiel Rouse qualified as a Licentiate of the Royal College of Physicians of Edinburgh in 1871, taking his membership of the Royal College of Surgeons (England) in the same year. D. Charles Cox L.M., L.R.C.P.E. first appeared in the Medical Register in 1871. Kennedy and Wood both took the new Bachelor of Medicine (M.B.) and Master of Surgery (C.M.) degrees in 1870. Kennedy graduated with honours, aged 23, shortly after taking up his post at the ERMH. William Wood, then aged 22, did the same.

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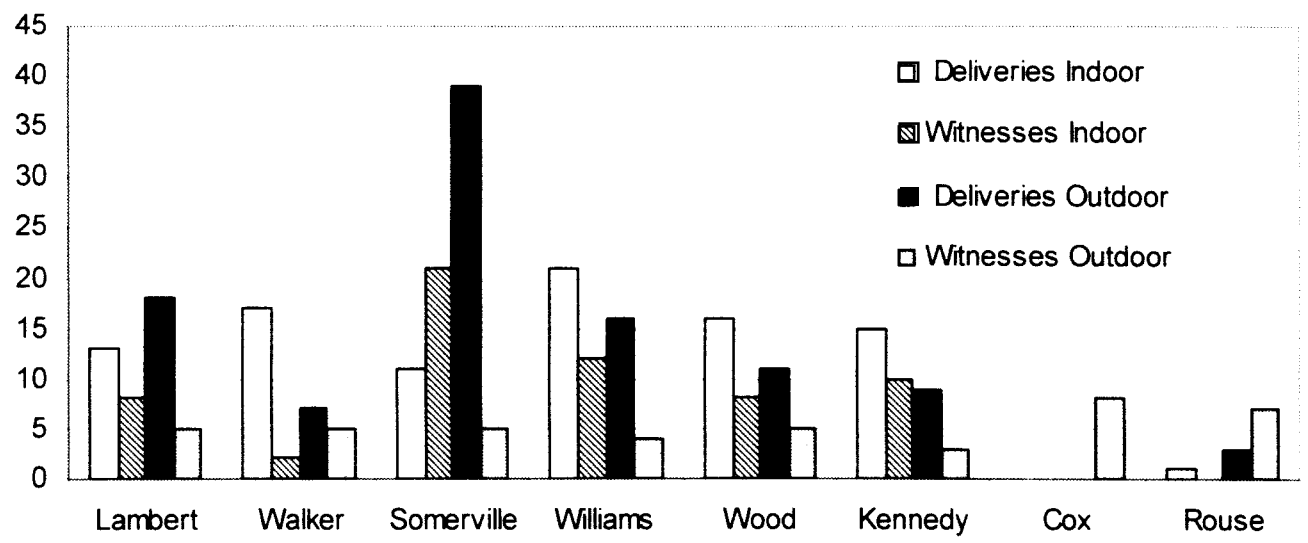
[39] See, especially 1870 ICB, case 1615 [031/1615/70fi] (Mrs Airey).
[40] 1870 Medical Examinations: Bleloch.

They both recorded their practical midwifery experience on their examination schedules: each had delivered six cases, at the City Parochial and New Town Dispensaries respectively.[42] Thus, as in 1850, the house surgeons were typically senior students or on the point of qualification, and probably starting with minimal midwifery experience.

The house surgeons' experiences, in the order in which they held their posts at the ERMH, can be seen in Figure 5.6, whilst Figure 5.7 shows the period in which they were present at the ERMH. In the first half of the year the house surgeons appear to have been in post for variable periods of time (Figure 5.7). Somerville, for example, was active in the Dispensary from the beginning of the year, although he only appears in the Indoor record at the beginning of April. This accounts for the much greater than average number of deliveries that he attended. Lambert and Walker are recorded in both books from the beginning of the year until early April, when Williams and Somerville took over their duties. Kennedy and Wood apparently started at the end of July, continuing until Cox and Rouse took over in November. With the exception of Somerville, the house surgeons' experiences were more evenly divided between Indoor and Outdoor than in 1850. Approximately a third of their experiences were witnessing deliveries, largely as a result of their increased role in teaching students, especially the female pupils. This was an increase from 1850.

Figure 5.6
Numbers of Deliveries Carried Out and Witnessed by House Surgeons at the ERMH in 1870, Indoors and Outdoors.



[41] See 1870 OCB, case 544 [018/544/70fo] and others.

Source: ERMH Indoor and Outdoor casebooks, 1870

Figure 5.7
The Appearances of the House Surgeons at the ERMH, by Week, 1870

Lambert	**********.....
Walker	.***..*..******.....
Somerville [a]	******.*******.....
Somerville	.....********.*****.....
Williams	.....**********.....
Kennedy	.....*....**********.....
Wood	.....**********.....
Rouse	.....****.**
Cox	.....***.*

Source: ERMH Indoor and Outdoor casebooks, 1870
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

[a] denotes the period when Somerville is not called a house surgeon, and carries out only Outdoor deliveries

Table 5.5
Type and Number of House Surgeons' Experiences at the ERMH, 1870

	Indoor	Outdoor	Total
Total House Surgeon Deliveries	94	103	197
Total Deliveries accompanied by Senior	2	2	4
Total Deliveries accompanied by Male or Female Pupil(s)	24	22	46
Total Cases Witnessed (includes duplicate cases) [a]	61	43	104
Total Cases where Witnessed Delivery by Senior (includes duplicate cases) [a]	11	4	15
Total Cases where Witnessed Delivery by Male or Female Pupil	44	39	83

Source: ERMH Indoor and Outdoor casebooks, 1870

[a] That is, witnessed by more than one house surgeon.

In four cases in 1870 the house surgeon delivered accompanied by a senior doctor (Table 5.5): on three occasions these were forceps deliveries. All the cases where the house surgeons watched their seniors deliver were complex, including version,

[42] 1870 Medical Examinations: Wood, Kennedy.

forceps deliveries, twins, craniotomy and induction. Although overall there were very few complicated cases treated by the ERMH, a determined attempt appears to have been made to use these for teaching the house surgeons. Only one such case was delivered un-witnessed.[43]

Although in 147 cases the house surgeon apparently delivered alone, in 46 he delivered in the presence of pupils, including two forceps deliveries. Indoors, all the pupils were female: they saw 14 cases delivered by the house surgeon, including two breech presentations. Outdoors, the witnesses were again principally pupil midwives: the eight cases where a medical student was present include two complex cases, one where the mother was suffering from 'annsarca', and delivered a stillbirth, and two cases where manual removal of the placenta was necessary.

The great majority of cases witnessed by the house surgeons were delivered by pupils, again principally female. Indoors, 44 pupil deliveries were seen, only one by a medical student. The majority of these were normal, although two were described as 'head & arm' presentations and two were breech. Most pupil cases witnessed Outdoors were also delivered by midwives: only three involved medical students. Again, most were problem-free. However, in three cases a third stage problem was recorded, so the house surgeon may have been called only at this point. In five cases a plausible reason for first-stage delay was recorded which would have justified sending for the house surgeon.

In 1870 the ERMH provided its house surgeons with an average of 38 experiences each, a decline from the average of 70 in 1850, but still including a wide range of normal delivery experience.[44] Practical instruction in the management of problematic childbirth was still minimal, due in part to the nature of the cases presenting at the hospital, and in part to the prevailing attitude to childbirth. House surgeons were

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[43] 1870 ICB, case 1713 [016/1713/70si].

[44] House surgeons were aware of the drop in patient numbers, and resented it. At the end of his stay in January 1870, Walker wrote to the Directors: '... Gentlemen. As there have been so few applicants for admission into your institution during my term of office as one of your House Surgeons I have the honor to request that I may be reappointed for the next three months.' (DMERMH, 17 January, 1870). This accounts for his stay until April.

confined to normal cases, and some now felt this restriction was irksome and unsafe.[45]

Five of those whose careers are known took the midwifery experience they had gained into general practice. Somerville established himself in Galashiels. Cox settled first in Penicuik and later in Arran. Rouse returned to Devon, presumably as a GP, but also becoming Medical Officer to Bideford Union, and Honorary Surgeon at Bideford Infirmary and Dispensary. Walker settled in Greenwich, and had a similar appointment at the Greenwich Union Infirmary. Kennedy took a house physicianship at the Royal Infirmary in 1874, and also at this time was awarded additional degrees from Würzburg and Vienna. In the same year he was described as Assistant Surgeon to Kirkcudbright County Poorhouse and General Prison. By 1876 he was in practice in Dalkeith, where he died in 1883. William Wood died in 1874, apparently without a further post.[46] The casebook and biographical data relating to the house surgeons show that since 1850 there had been little change in either the nature of the appointees and their ambitions, or in the experience they had at the ERMH.

5.4.3 Medical Students

In 1870 27 medical students attended the ERMH for their practical midwifery experience. Of these, 17 were matriculated university students, three came from the extra-mural schools, two were visiting students, and five were untraced. Although the variation is less marked than in 1850, they had a wide range of experience at the hospital, and this is again shown as a cumulative graph.

From the graph it can be seen that seven students accounted for over 50% of the students' experiences. Again, the careers of these and the six students with fewest deliveries, who do not appear at a year-end, have been further examined (Table 5.6). In the 'low' group, one remains untraced, whilst there is insufficient data to identify

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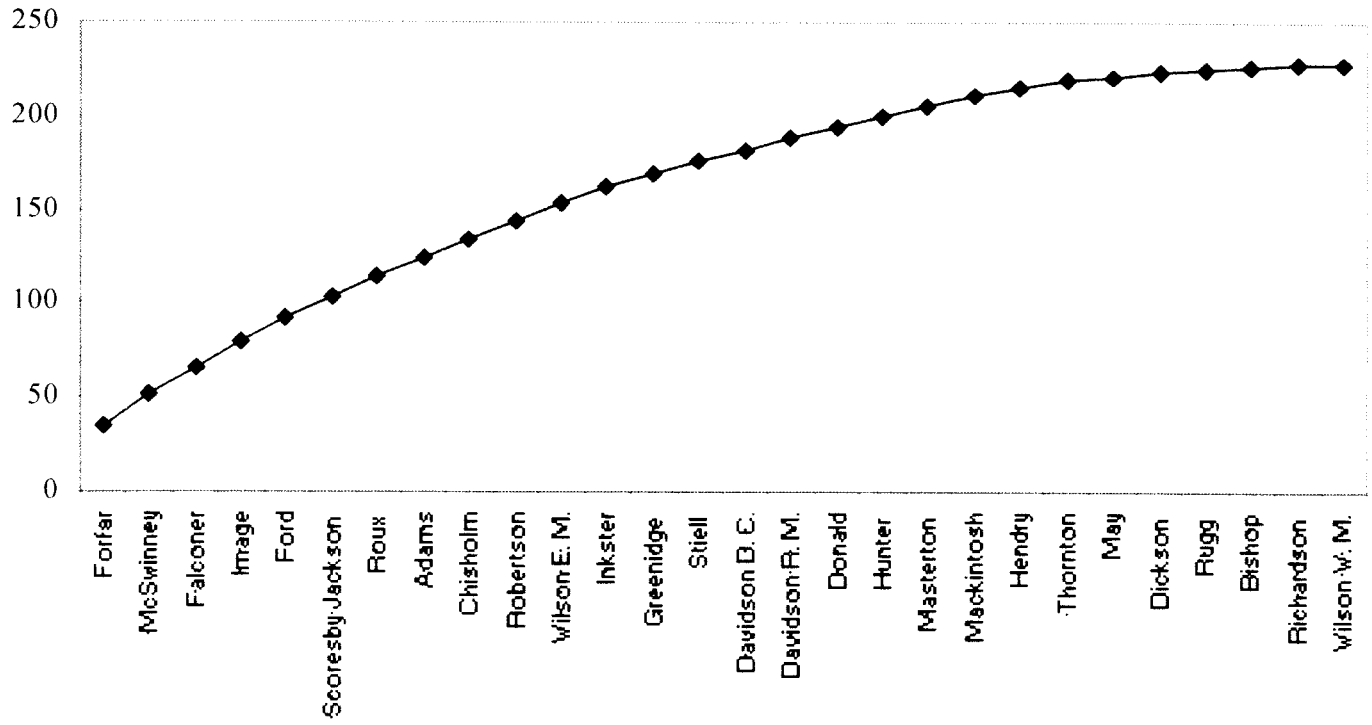
[45] In September 1870 Kennedy wrote, following the fatal outcome of Williamina Bayne's delivery, which he evidently felt would have been happier if there had been earlier intervention: 'as the House Surgeon ... is not allowed to perform an obstetric operation on his own responsibility, unless there be immediate danger ... I reluctantly withdrew my hand ....' (1870 Special & Ordinary Casebook [SOCB], p. 38).
[46] LPMD, 1870, 1872, 1874, 1880, 1885, 1890, 1896, 1901.

two. In the 'high' group, only Forfar remains untraced: whilst still a student, he was House Surgeon at the ERMH in April 1871, but thereafter does not appear in either the Medical Register or Directory.[47]

Figure 5.8
Cumulative (Pareto) graph of the Experiences of Medical Students attending the ERMH in 1870



Source: ERMH Indoor and Outdoor casebooks, 1870

Table 5.6
ERMH Medical Students Selected for Further Examination, 1870

Name	Number of Experiences	Career
Forfar	35	Not traced
McSwinney	17	General practice
Falconer	14	General practice
Image	14	General practice
Ford	12	District Medical Officer
Scoresby Jackson	12	General practice
Roux	10	General practice
Mackintosh	5	General practice
Hendry	4	Not traced
Thornton	4	Gynaecologist
May	2	General practice
Dickson	2	Insufficient data
Rugg	2	Insufficient data

Source: ERMH Indoor and Outdoor casebooks, 1870; Medical Register and Directories

[47] RGS, *Census of the City of Edinburgh*, 1871, Registration District 685[4], Enumeration Book 70.

Each subgroup contained matriculated students, but non-matriculated students appear only in the 'high' group. There is more variety in the nature of their eventual qualifications than in 1850. McSwinney took his degree from Queen's University, Belfast, presumably having had special leave to attend Simpson's lectures. Ford, Image and May were all matriculated, but became members of the Royal Colleges, as did Falconer, who was not a matriculated student. Others took the new M.B. and C.M., as some of the house surgeons had done.

Table 5.7 shows the years of first registration with the GMC for both the selected medical students and the house surgeons, where traced.

Table 5.7
Years of First Registration with the General Medical Council for Selected Medical Students and the House Surgeons at the ERMH in 1870

	1869	1870	1871	1872	1873
House Surgeons [a]	1	2	1	0	1
Medical Students	0	3	3	1	2

Source: Medical Registers, 1869-73

[a] Plus one in 1858.

This year has been chosen as an indicator of when they considered themselves to be qualified. It can be seen that both groups are very similar in this, as in their age, and the conclusion must be, as in 1850, that there was little difference in medical experience between the majority of house surgeons and the medical students.

The experiences of the medical students are seen in Table 5.8. Again, as in 1850, the medical students witnessed very few cases, in relation to the number that they delivered. These can be seen as individual experiences in Figure 5.9.

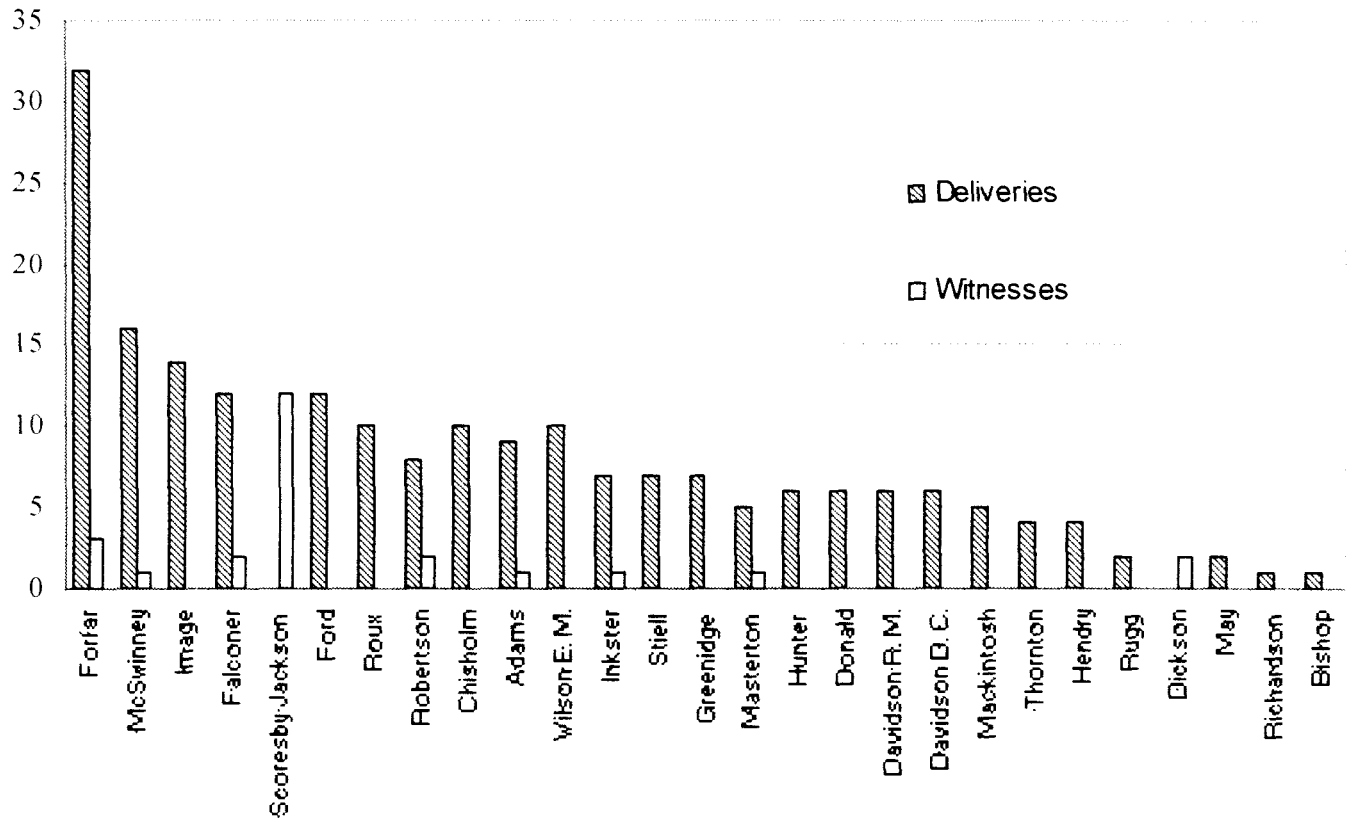
Table 5.8
Number and Type of Medical Students' Experiences at the ERMH, 1870

	Indoor	Outdoor	Total
Total Medical Student Deliveries	1	201	202
Total Deliveries accompanied by Senior	0	4	4
Total Cases Witnessed (includes duplicate cases) [α]	1	24	25
Total Cases where Witnessed Delivery by Senior (includes duplicate cases) [α]	1	10	11

Source: ERMH Indoor and Outdoor Casebooks, 1870

[α] That is, witnessed by more than one medical student.

Figure 5.9
1870 Numbers of Cases Delivered and Witnessed by Medical Students at the ERMH, 1870



Source: ERMH Indoor and Outdoor Casebooks, 1870

The exception is Thomas Scoresby Jackson, who invariably accompanied T. Henry Ford to his deliveries. This may be the result of the way in which they recorded their cases, or it may be genuine. Scoresby Jackson had attended Keiller's lectures in midwifery at the College of Surgeons in 1868, before taking Simpson's course in 1869-70. Unfortunately he described his practical midwifery experience as an undated '6 mos. at Maternity 6 mos. at Parish Disp' without giving the number of cases, which could have been substantial, and might well have encouraged him to let

his colleague take all these cases.[48] Other medical students rarely saw deliveries. Mr. Robertson saw a long forceps delivery by Doctors Ziegler and Bell, whilst George Adams saw Ziegler perform podalic version. Forfar was present when Charles Bell supervised Kennedy performing a forceps delivery, and Samuel Inkster was similarly present when Walker was Bell's pupil. On two occasions Lambert, the house surgeon, was recorded as performing a delivery with students present, when his comment in the 'Remarks' column makes it clear he was called because of a retained placenta.[49]

The great majority of cases delivered by the medical students were problem-free. In five cases the presentation was breech, and all these were delivered by the student on his own. Ford and Scoresby Jackson coped with a face presentation. Help was more likely to be sought for a third-stage problem. Three postpartum haemorrhages were recorded among student cases: in two no help was called, and both mother and child were described as 'well' on discharge. In the third, James May called Cox to attend, and the mother's health at discharge is not recorded.[50] On four occasions the students recorded a retained placenta, and the house surgeon was called twice, whilst the student coped alone twice.[51] Five times the labour attended was described as slow or tedious, although in only one was help sought.[52] Thus, as in 1850, the medical students received and sought minimal guidance from the house surgeons, and had extremely limited experience of the complications of labour.

As in 1850, medical students were expected to furnish evidence of experience of practical midwifery before their final examinations. Four of the records for students at the ERMH in 1870 have been found, of which two give a number of cases. Edward Moon Wilson is recorded as attending ten, both in his examination schedule and the casebooks. However, John Knowsley Thornton claimed six, but is only recorded as attending two cases in July and two in November. These two examples,

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[48] 1871 Medical Examinations: Scoresby Jackson.
[49] 1870 OCB, case 597 [063/597/70fo].
[50] 1870 OCB, case un-numbered [160/-/70so].
[51] In these cases, the presence of the house surgeon was only recorded in 'Remarks'. For example, 'Dr. Rouse sent for to remove placenta …'. (1870 OCB, case un-numbered [135/-/70so]).
[52] 1870 OCB, case 5061 [096/5061/70fo].

and Bleloch's record, suggest that students typically attended one source of practical midwifery experience, Scoresby Jackson being an exception to this.[53] The midwifery experience provided by the ERMH was typical for the time in Edinburgh. Students who attended local dispensaries commonly had between six and 30 cases.[54]

On average, the students of 1870 carried out eight deliveries, in contrast to the 12 cases in 1850. As in 1850, there seems little correlation between the number of deliveries as students and future interest. In the high scoring group, the lack of further career information on Forfar, by far the most active student, and with a house surgeoncy at the ERMH, is unfortunate. Three others of his group became general practitioners. After a period as a district surgeon in Ceylon, in 1880 McSwinney was elected a Fellow of the London Obstetrical Society, suggesting a sustained interest in the health of women and children. By 1885 he had emigrated to New South Wales. Roux returned to the Cape of Good Hope, whilst Ford became a District Medical Officer in British Guiana. Three of the 'low' group have been firmly identified. May and Mackintosh went into general practice, while, perversely, Thornton, who recorded only four cases in 1870, and who only claimed six in total, pursued a career in gynaecology. After a house surgeoncy at the Royal Infirmary, by 1880 he had become surgeon at the Samaritan Free Hospital for Women and Children in London, and author of a number of papers on ovariotomy, abdominal section, and pelvic surgery. He later became consultant surgeon at the Grosvenor Hospital for Women and the New Hospital for Women.[55]

As in 1850, the casebook data and biographical information for the medical students indicate that they conformed well to the requirements made of them in the hospital rules, and that they easily achieved their necessary cases. They had copious practical midwifery experience at the ERMH, which equipped them well for general practice

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[53] 1870 Medical Examinations: Bleloch; 1871 Medical Examinations: Scoresby Jackson, Thornton, Wilson.
[54] For example: William Wylie attended 'Dr. M. Duncan, Royal Dispensary, Richmond Street' for six cases; R.H. Alleyne had a 'certificate of attendance on 30 cases' from the same dispensary. (1870 Medical Examinations: Wylie; 1871 Medical Examinations: Alleyne).
[55] LPMD, 1853, 1872, 1874, 1880, 1885, 1890, 1896, 1901, 1906, 1913.

to which most of them went. Again, there was no significant difference between the 'high' and 'low' groups of students in their future careers.

5.4.4 Midwives/Nurses

Figure 5.10
Appearances of the Midwives at the ERMH, by Week, 1870

Thorburn	****.**..*.....
Parmenter	.***.....
Campbell	.**.....
Cameron	.*.*.....
Leslie	....*..*...*****..*..**.....
Moyes	.....*.....*.....
Gunn	......**...****.....
Simpson	........*.*****.....
Hutton	........*.*.***.....
Rutherford	...........*..*.*.**.....
McLaughlin	.............*......***.....
Leadbetter	.............***...***...*.....*.....
Campbell (May)	.............*.....******.....
Richardson	.............*...****.....
Geddie	.............*...*.***.....
Sutherland	.....*.**.**********.*.*.....
Mitchell	.....***.....
Midwife	.....*.....*.....
Cochrane	.....*****.....
Ritchie	.....***.*****.*
Jack Miss	.....*.**...*...
Scott	.....***.**.
Oswald	.....***...*
Keating	.....***.**
Macdonald	.....**.***
Swanson	.....*...*
'Nurses'	...........*.*.***..******....*.*...*..*.....

Source: ERMH Indoor and Outdoor casebooks, 1870
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

In 1870 the names of 25 women occur in the 'by whom delivered' columns of the casebooks. They were no longer called midwives, but were recorded variously as 'Mrs' or 'Nurse', whilst their lecture certificates were now headed 'Nurse's

Midwifery Diploma'. However, their experiences were similar to those of the midwives of 1850, and they went on to work as midwives. The pattern of the appearance of their names in the casebooks (Figure 5.10), although not distinct, suggests that they were attending classes, in groups of four or five.[56] The variation in their stay, as indicated by their weekly activity, remained wide, being 2-21 weeks. Most stayed for 8-10 weeks.[57]Additional evidence for the existence of classes comes from the Annual Report for 1870, which declared their intention to establish 'a proper school for the instruction in Midwifery and the treatment of Diseases of Women and Infants, both to students and nurses',[58] and from various recorded discussions by the Medical Board. In 1868 Charles Bell 'submitted ... that there should be a difference in fee for nurses who are taught in the Hospital and those who attend lectures elsewhere',[59] whilst in 1873 Keiller hoped to bring all instruction for nurses within the Hospital, the lecturer being the Medical Officer for the quarter.[60]

The experience of the nurses at the ERMH can be seen in Figure 5.11. This shows that most attended both Indoor and Outdoor deliveries, but that the numbers and predominance of each varied between midwives. On average, each midwife delivered four Indoor cases and three Outdoor.[61] The content of the nurses' experience is shown in Table 5.9.

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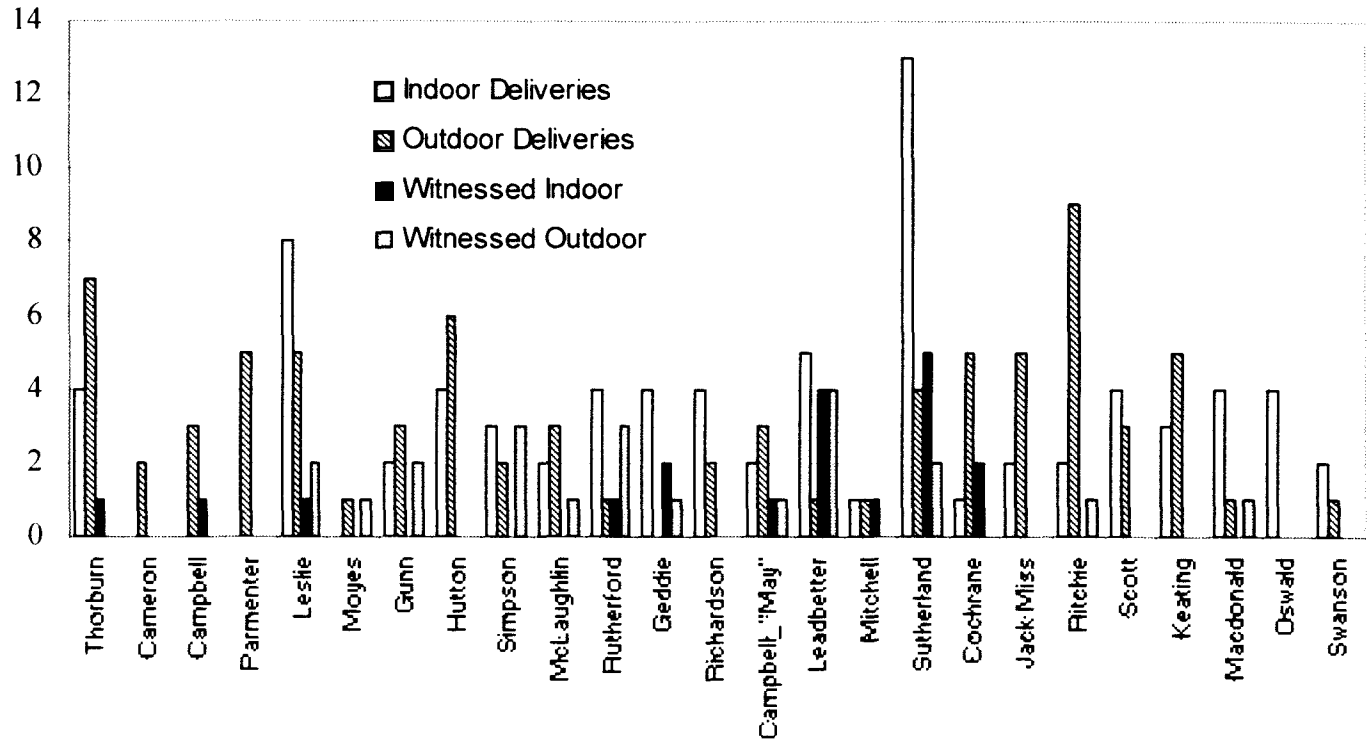
[56] The following year five women described as nurses were present in the ERMH on census night. (RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 70).
[57] Median 7 weeks; mean stay 9 weeks, distorted by the longer stays of Mrs Leadbetter and Mrs Sutherland.
[58] ARERMH for 1870.
[59] DMERMH, 11 November 1868.
[60] MBMERMH, 1 April 1873.
[61] Drs Somerville and Williams did not record the names of female pupils witnessing deliveries from mid-April until mid-July, and these cases are excluded from this figure. Typically, they used such phrases as 'all the nurses'. See, for example, 1870 ICB, case 1654 [070/1654/70fi].

Figure 5.11
The Number of Cases Delivered and Witnessed by Nurses at the ERMH in Approximate Order of Appearance, in 1870



Source: ERMH Indoor and Outdoor casebooks, 1870

Table 5.9
Type and Number of Nurses' Experiences at the ERMH, 1870

	Indoor	Outdoor	Total
Total Nurse Deliveries	78	78	156
Total Deliveries accompanied by Senior	43	31	74
Total Cases Witnessed (includes duplicate cases) [a]	43	23	66
Total Cases where witnessed Delivery by Senior (includes duplicate cases) [a]	17	15	32

Source: ERMH Indoor and Outdoor casebooks, 1870

[a] That is, cases seen by more than one nurse.

In 43 cases Indoors, nurses delivered in the presence of a house surgeon, and presumably under his supervision. The great majority of cases were normal, although two were breech stillbirths. In a further 35 Indoor cases they delivered alone, and these also included a further breech stillbirth. They watched the house surgeon deliver in 31 cases.[62] This group of cases included five breech presentations, five late abortions, an infant with a caul, and two postpartum haemorrhages. In ten cases they

[62] This figure includes 12 entries where the nurses are not identified individually.

watched a colleague deliver. In addition, unspecified 'nurses' saw Charles Bell carry out two long forceps deliveries. This degree of supervised activity and observation suggests that in 1870, within the hospital, a determined attempt was made to educate nurses attending in the management of normal labour.

Outdoors, house surgeons apparently observed midwives deliver in 30 cases. However, in two of these, an un-named midwife required assistance with a retained placenta. Since the house surgeons also attended a similar problem for a Mr. Crane of the Parochial Dispensary, it can be surmised that all three cases only became involved with the ERMH when the problem arose.[63] The remaining cases included twins, two breech presentations, two premature births, and delay through an impacted anterior lip of cervix. In this final case Mrs Campbell delivered the first twin but 'Dr. Lambert delivered 2nd with forceps ... impacted 4 hours', Charles Bell also being present.[64] In 41 cases the nurses delivered by themselves, and these cases included three breech presentations, and one case where 'Nurse says it was a Face presentation but as the face was not the least swollen, this diagnosis is very doubtful.'[65] In 15 cases nurses witnessed Outdoor deliveries by the house surgeon. Again the great majority of these were problem-free, although one was described as a face presentation, and one was protracted.[66] Finally, 'nurses' saw a difficult twin delivery, when 'Dr. Kennedy applied Long forceps to 2nd. child - Present Prof. Simpson.'[67] Overall, nurses did have the opportunity to see unusual cases Outdoors, and an attempt at instruction and supervision appears to have been made, but it was less successful than Indoors, presumably due to the logistical problems involved.

Evidence also survives that the nurses of 1870 were also engaged in a small amount of nursing care, rather than specifically delivery care. By that year most in-patients stayed for seven days after delivery, and were on bedrest for 4-5 days. Any

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[63] 1870 OCB, cases 5230, 5271 and 5275 (Crane) [032/5230/70so, 073/5271/70so, 077/5275/70so].
[64] 1870 OCB, case 568 [034/568/70fo].
[65] 1870 OCB, case 5300 [101/5300/70so]. The comment suggests that Kennedy investigated Mrs Cochrane's claim. The remaining cases were attended by two nurses, or, in one case, by a nurse and medical student.
[66] 1870 OCB, case 707 [082/707/70fo].
[67] 1870 OCB, case 5288 [090/5288/70so].

suggestion of ill health could lengthen this time considerably. Six instances of nursing treatment are recorded in the Special and Ordinary Casebook, apparently ordered, rather than carried out, by the house surgeon. Suspicion of infection led to a busy regime of vaginal douching. In addition, on 20 October, Mrs Sutherland, rather than the house surgeon, gave ergot to Elizabeth Gair, whose 'uterus after labour showed symptoms of relaxing', whilst on 28 July, when Elizabeth Good suffered a postpartum haemorrhage four hours after delivery, 'Mrs Leadbetter applied cold and stopped it.'[68]

A small amount of biographical evidence from around this period suggests both that female pupils at the hospital intended to work as midwives, rather than solely as monthly nurses, and that they did so satisfactorily. Mrs Elizabeth McDonald, Abbeyhill, offered in support of her initial entry on the Edinburgh Corporation Register of Midwives, her 'certificate from old Maternity Hospital Edinburgh ... 1876'. She carried out nine deliveries in August and September of that year, being described in the Indoor casebook on 21 September 1876 as 'Nurse McDonald'.[69] In 1879, Mrs Mary Simpson, who practised as a midwife in Wick, attended Professor Alexander Simpson's 'course of instruction for Midwives' and concurrently the ERMH, where 'she delivered and had the entire management in 15 cases'.[70] The presence of more nurses in the hospital on Census night, 1871, provides a little insight into their circumstances. As the then Matron was not a midwife, there was a Head Nurse who was, Barbara Baillie Macdonald, aged 43 and married. There were five nurses, aged from 24 to 49, with an average age of 33. Three were married, one was single, and one widowed. Four were Scots, but none were born in Edinburgh.[71]

Unusually, in the face of later opposition to midwives, in 1870 the hospital data suggest that the then management was putting emphasis on the teaching and

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[68] 1870 SOCB, pp. 80, 6.
[69] The quotation is from a photocopy of her Register entry [LHSA, LHB MAC GD 2/10/1&2]. She enrolled with the Central Midwives Board for Scotland on 20 October 1916. In the period 1885-1916, when her practice can be traced in Post Office directories, she advertised herself as a midwife only.
[70] Certificates dated 29 April and 1 May 1879 respectively, and sent by the Wick Historical Society to the LHSA for identification, Spring 1997.
[71] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 70.

supervision of female pupils to become effective assistants for medical practitioners. This was not necessarily against the wishes of contemporary doctors. Writing in 1858, John Brown M.D. urged his readers to '[t]ake pains to educate carefully, and to *pay well*, and treat well these women, ... to conduct victoriously the normal obstetrical business', to enable the local doctor to confine himself 'to giving [his] advice and assistance to the midwife when she needed it'.[72] Some letters in the *Scotsman* in 1863 suggest that James Matthews Duncan, lecturer in midwifery to medical students at the Extra-Mural School, had introduced some nursing reforms, although the nature of these is not explained.[73] One of his pupils left a description of herself, which accords well with the training available to midwives at the ERMH in 1870:

> 'I have been in practice in the Braes of Lochaber for 40 years. I was trained by Dr. Matthews Duncan. I was taught by him to exercise patience and never to get flustered or to hurry. I have never had a death at a confinement. The cases were mostly "natural". Few required a doctor. I judged by experience when to send for him.'[74]

Older Scots doctors, who gave evidence to the Select Committee on Midwives' Registration, referred to the benefits of having such an assistant. They were criticised both by younger, more specialised doctors, and by those who wished to create an independent profession of midwifery in a medical context.[75]

In organisational terms, the ERMH had changed little from 1850. Senior doctors still attended emergencies when they were called, and available. There continued to be little difference between house surgeons and medical students. Nonetheless, there were changes in the training of midwives. They now had an additional nursing role within the hospital, were being well taught by the house surgeon, and may have been

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[72] John Brown M. D. *Horae Subsecivae*, (London: Adam and Charles Black, 1897 edition (first published 1866)), pp. xliv-xlvi.

[73] The letters refer to the establishment in Edinburgh of an employment agency for skilled nurses, sometime before the Nightingale-inspired reforms at the Royal Infirmary. (*The Scotsman*, 16 February (editorial), 18, 19, 25 February 1863 (letters)).

[74] Thomas Ferguson *Scottish Social Welfare*, (Edinburgh: E. & S. Livingstone Ltd., 1958), p. 511. Sadly, the quotation is unreferenced.

[75] Dr Alexander Disney Leith Napier M.D., M.R.C.P., Director of Midwifery at St. Pancras and Northern Dispensary from 1887, spoke of his experiences as a GP in Scotland some 20 years before

encouraged to identify problems and call for assistance. However, despite this early evidence of stratification of attendants, in Edinburgh in 1870 parturition was still seen as a physiological process, in which the expectation was of natural delivery without interference, and in which evidence of problems had to be overwhelming before intervention. Again, the training available to male and female pupils reflected this attitude.

5.5 Evidence from 1890

5.5.1 Senior Doctors

Five senior doctors attended the ERMH regularly in 1890, seeing 21 cases in all. In addition, three postgraduate students, Drs. Webster, Jamieson, and Morton, attended 20 deliveries, of which three were complicated. By this period the senior doctors acted only in their allotted quarters at the ERMH. The sole exception to this was the only appearance of Professor Simpson, at a delivery by Prêvot's operation in June, in Underhill's session. From the description of this case, Simpson and Milne Murray were present as moral support to Underhill, then carrying out an experimental operation with an extremely high maternal mortality rate.[76] Berry Hart attended five cases between February and April, and Underhill six between May and July. The assistant physicians acted for six months at a time, Barbour from November until April, and Milne Murray from May until October.

Simpson's own quarter ran from November to January. He does not appear from the casebooks to have carried out any deliveries in these months, but instead to have made use of A. H. Freeland Barbour, the assistant physician for this and the next quarter. Barbour carried out three complicated deliveries for Simpson, but only one for Berry Hart, who was a much more active physician in the hospital. Halliday Croom behaved similarly. He did not appear in his August-October quarter, but relied on Milne Murray to take his cases. This apparent withdrawal from the ERMH

(P.P., *Report of the Select Committee on Midwives' Registration* 1892 (289) XIV, pp. 1-173, Evidence of A. D. L. Napier M.D., M.R.C.P., q:16).

[76] '... Prof. Simpson & Dr. Murray were called in & a Laparotomy decided upon.' (1890 SOCB, pp. 80-1). Milne Murray is not recorded as attending the operation in the Casebook.

by the current and future Professors can be explained in terms of their other commitments. Halliday Croom had a particularly busy schedule. In 1890 he held nine lecturing posts at the Edinburgh School of Medicine and the Minto House School. In addition, he was an examiner for the RCPE, and was also a physician at the Infirmary and with the Fountainbridge Dispensary. Simpson had an apparently smaller teaching schedule, although by 1890 he taught in both the winter and summer sessions at the University, for six mornings a week. He was also a physician at the Infirmary, and president of the EMMS. In contrast, Berry Hart, Barbour, and Milne Murray each held one lecturing post, whilst Underhill had none.

Without exception, the cases attended by senior doctors were complicated. Even when they resulted in a normal delivery, the patient was either systemically ill, or had been in labour for so long that the house surgeon needed advice. Typically, however, senior doctors performed more complicated instrumental deliveries, and the great majority of deliveries by version. Good use was made of these to demonstrate to the house surgeons, and Outdoors, to the original student attendants. Of the 19 individual cases, 17 were seen by at least one house surgeon. Seven were seen by both house surgeons, whilst all six complicated cases occurring Outdoors were seen by the male and female students allocated to that patient. Thus, those senior doctors who attended the hospital most frequently had a clinical input into the education of both the house surgeons and students.

By 1890 the casebook and biographical data show the commitment to education of the senior doctors, both in their lecturing role elsewhere (see Chapter 2, Section 2.5.1), and in the regular clinical management of cases in the gaze of house surgeons and, less frequently, students. Very few complicated cases were not seen by such trainees. The new division of responsibility over the hospital year also permitted a more personal relationship with the house surgeons. Overall, senior doctors appeared more confident: it is no longer possible tentatively to identify the more skilled and senior of the group. For example, deliveries by podalic version were carried out by all the doctors with the exception of Milne Murray and Simpson; abdominal surgery

was carried out by both Berry Hart and Underhill. They seldom needed the immediate support of their peers.

5.5.2 House Surgeons

In 1890 11 house surgeons attended the ERMH, usually appearing in pairs in five 'quarters' divided through the year as before (Figure 5.12).

Figure 5.12
The Appearances of the House Surgeons at the ERMH, by Week, 1890

Fordyce	****. . . . .
Lackie	***. . . . . *. . . . .
Fitzgerald	. . . **********. . . . . *. . . . .
Gibson	. . . ****. . . . .
Melville	. . . . . **********. . . . .
Turner	. . . . . **********. . . . .
Gillespie	. . . . . **********. . . . .
Armour	. . . . . **********. . . . .
Williams	. . . . . **********. . . . .
Paterson	. . . . . *********
Duncan	. . . . . *******. *

Source: ERMH Indoor and Outdoor casebooks, 1890
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

Overall, their appearance is very regular: only in the second quarter is there any variation, when Gibson appears to have stood in for Melville at the beginning of his shared stint with Fitzgerald. Both Lackie and Fitzgerald also made unexplained return appearances for 1-2 days, several months after they had officially finished.

The origins of eight of the 11 are known: five were Scots, one was from New Zealand, whilst two were English. With the possible exceptions of Melville and Fitzgerald, all were qualified and registered with the GMC before they took up their posts at the ERMH.[77] All took medical degrees, whilst four went on to take M.D.s in

[77] Melville, who came to the hospital in mid-February 1890, registered with the GMC in 1890, taking his membership of both Edinburgh Colleges and the Faculty of Physicians and Surgeons of Glasgow

the next four years. Gillespie was awarded a gold medal for this thesis, whilst Lackie passed with honours. Both Lackie (1889) and Paterson (1890) were James Scott Scholars, awarded for success in their final midwifery papers, and as such expected to take house surgeoncies at the ERMH. Fordyce held the Buchanan Scholarship. The 1890 house surgeons' careers prior to their appointments reflect how much more formally academic and standardised the medical syllabus had become since 1870. The calibre of the appointees suggests that a period working at the ERMH had become a desirable experience for young doctors, and that the Medical Board was able to make its selection from a range of candidates.

An increasing amount of study before appointment also meant that on average the house surgeons on 1890 were older than their predecessors of 1870. The years of birth of seven are known: Duncan, in his 22nd year, was the youngest. Most were between 24 and 27: Turner was 32. Armour had previously had a house-physicianship at the Royal Infirmary. Age and education now distinguished the house surgeons from the medical students in a way that was not apparent in the two previous years studied.

Understanding the experience the individual house surgeons now received at the ERMH is complicated by the change in entering delivery details that occurred in the Indoor Book after 1886. Unqualified personnel at deliveries were no longer listed, so that a picture of the house surgeon's teaching role Indoors can no longer be built up, although two surviving nurses' hospital certificates, and one for a medical student, suggest that it continued.[78] However, house surgeons continued to record each other's presence at deliveries, and also that of their seniors, and Outdoors the listing of all personnel continued. The overall experience that the 1890 house surgeons had at the ERMH can be seen in Figure 5.13. From this it can be seen that the majority of

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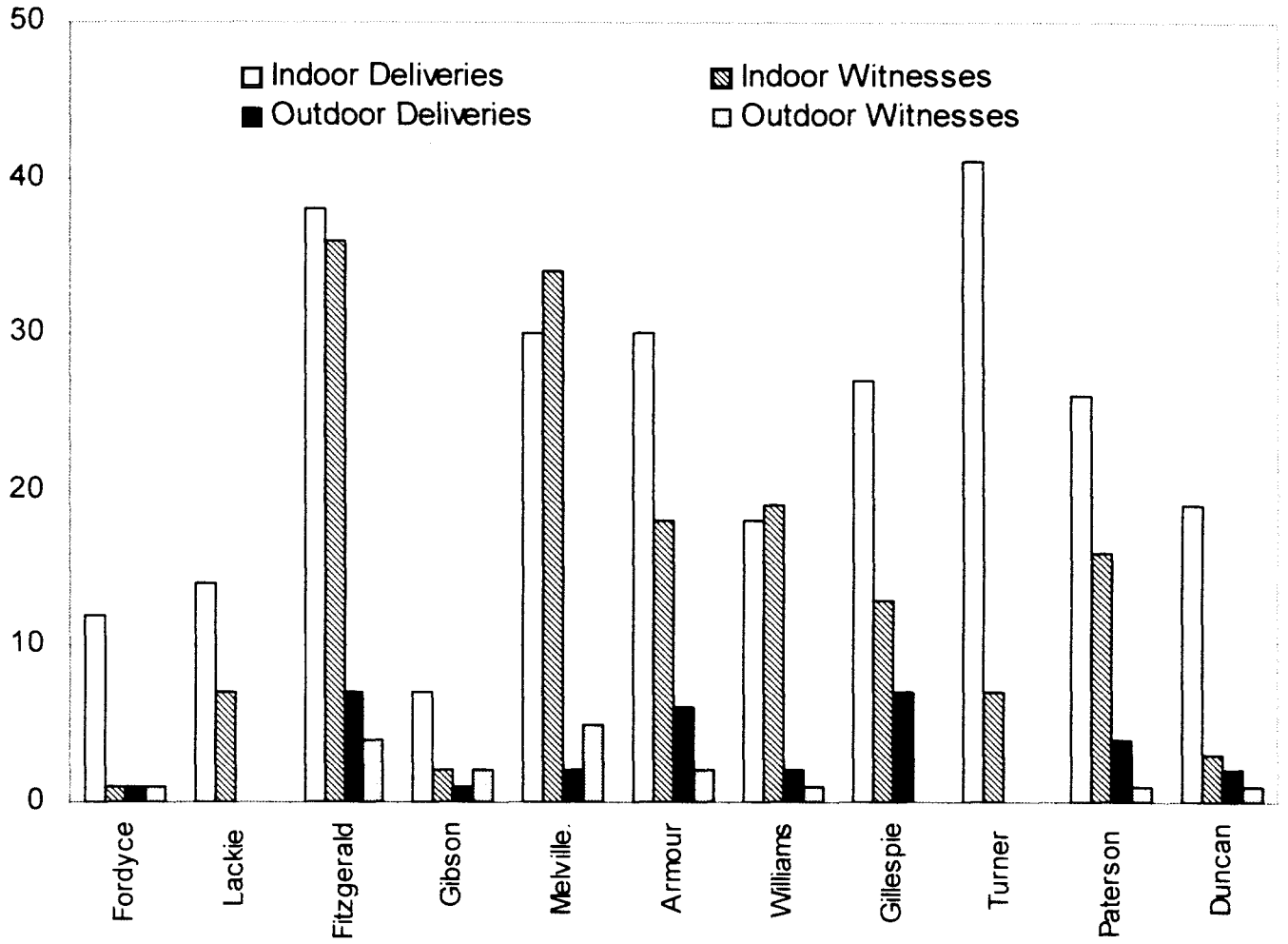
in that year, but passing his M.B. and C.M. in 1891. Fitzgerald also registered with the GMC in 1890, taking a hospital appointment in February, but he had passed his M.B. and C.M. in 1889. However, his examination schedule is bound with those of 1890. (1890 Medical Examinations: Fitzgerald).

[78] See, for example, the certificates of 'Mr. Robert Thin', 1886-7, [LHSA, LHB 3/38/23], Mrs Jane Todd, 1885, [LHSA, LHB MAC GD 1/35/2] and Miss Mary Morrison, 1886-7, [LHSA, LHB MAC GD 1/77/3], which is Illustration 5.2, at the end of this chapter.

their experience was Indoors, Lackie and Turner apparently having no Outdoor experience.

Figure 5.13
Numbers of Deliveries and Cases Witnessed by House Surgeons at the ERMH, Indoor and Outdoor, in Approximate Order of Appearance, 1890



Source: ERMH Indoor and Outdoor casebooks, 1890

The experience house surgeons received at the ERMH can now be expressed in two ways. Table 5.10 shows a further breakdown of that experience, in terms of supervision or teaching, as reconstructed from casebook entries. Table 5.11 shows it in terms of the nature of the experience, compared with those of the students.

On only one occasion was the house surgeon accompanied at delivery by a senior doctor, and then Berry Hart may have been called to help with a heavy 'Post partum Haemorrhage stopped by pressure on uterus Douching with hot water & Ergot', rather than to attend the entire delivery.[79] Thus, in sharp contrast to former years, the

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[79] 1890 ICB, case 37 (Dr Berry Hart's quarter) [DBH] [063/37bh/90fi].

house surgeons apparently received no supervision in any of the 70 forceps deliveries they carried out, nor on the two occasions when they delivered by podalic version.

Table 5.10
Number and Type of House Surgeons' Experience at the ERMH, 1890

	Indoor	Outdoor
Total House Surgeon Deliveries	262	32
Total Deliveries Accompanied by Senior	1	0
Total Deliveries Accompanied by Male and Female Pupil(s)	0	32
Total Cases Witnessed (includes duplicate cases) [a]	156	17
Total Cases where Witnessed Delivery by Senior	19	7
Total Cases where Witnessed Delivery by Male or Female Pupil	0	5

Source: ERMH Indoor and Outdoor casebooks, 1890

[a] That is, cases witnessed by more than one house surgeon.

Table 5.11
The Nature of House Surgeons' and Pupils' Experiences Recorded at the ERMH (Numbers), 1890

	House Surgeons	Medical Students	Midwifery Nurses
Normal Deliveries	192	471	89
Forceps Deliveries	70	1	0
Breech Deliveries	13	16	2
Twin Deliveries	3	4	2
Version	2	0	0

Source: ERMH Indoor and Outdoor casebooks, 1890

However, they were able to see their seniors in action in ten Indoor cases, all complicated. Induction followed by version was demonstrated by Berry Hart, breech and a triplet delivery by Underhill, and forceps and the care of a cardiac patient by Barbour. Outdoors, the house surgeons also saw a variety of interventions by their seniors, including Prevôt's operation for amputation of the uterus, caesarean section, version and forceps. Only two cases of the 19 thought sufficiently complex to be delivered by a senior doctor went apparently un-witnessed by the house surgeons, suggesting that they were encouraged to see such cases, even if they were not themselves observed.

The altered nature of the experience of the house surgeons (see Table 5.11) represents an extremely significant change in the practice of the hospital. The unchanged nature of the post indicates indisputably that they were there to learn more about obstetrics. However, the expectations of them, in terms of the unsupervised deliveries they conducted, indicate major changes in the approach to the process of parturition at the hospital. As discussed in Chapter 4, the event of birth itself was now more rigorously classified into normal and abnormal, and that classification was acted upon rather than only observed. This presented the medical staff with the options of attending deliveries more frequently, or training the house surgeon in forceps deliveries. Thus, as will be seen in regard to students, the change in approach to labour and delivery, and greater emphasis on the role of the doctor in abnormal cases, led to an increased stratification in the role of doctors at delivery.

The casebooks also imply that the house surgeon's teaching role was severely reduced, although Indoors this is belied by the evidence of surviving hospital certificates.[80] Outdoors, he was observed at delivery on 32 occasions, by both medical students and nurses. All these cases bar one required intervention which medical students could not usually provide, including the 'clearing out' of abortions.[81] At 22 of these cases the house surgeon used forceps to deliver, most commonly for second stage delay. On four occasions he carried out a breech delivery. However, it was still the norm for students of either sex to deliver breech presentations unsupervised, this occurring in a further 18 deliveries. Finally, Williams and Armour together attended a protracted but successful twin delivery, in the presence of Miss Cadell, Mr. Salmon, and two nurses, although again students delivered six sets of twins unaided.

However, the records show increasing routine supervision and advance instruction by the house surgeon: for example, 'Dr. Gillespie called at 8.30 a.m., found one leg in Vagina and delivered child at once.'[82] In the case of Mrs Morrison, delivered by

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[80] See footnote 78.
[81] The exception was described as 'laborious', so presumably Gillespie had been called in expectation of a forceps delivery. (1890 OCB, case 116 (Dr Underhill's quarter) [CEU] [337/116u/90fo]).
[82] 1890 OCB, case 128 CEU [002/128u/90so].

version after forceps delivery failed, the attending student had been furnished with either general or particular guidelines, as, when strong pains failed to 'advance the head ... [he] accordingly sent for the resident on duty'.[83] Similar guidelines may be behind Paterson's presence at Mrs Watson's delivery when '[c]ervix fully dilated membs unruptured for 1½ hours Dr Paterson ruptured membs & child born in 2 minutes. No haemorrhage.'[84]

On the five occasions when the house surgeon was recorded as witnessing a student delivery, in fact the case was one of abortion to which he was summoned to ensure the uterus was empty. The house surgeon was called to approximately half the cases where students had third stage problems, usually to remove the placenta manually. However, students of both sexes reported problems at delivery in 32 cases when the house surgeon's presence was not recorded. Most commonly, the problem was prematurity, but students coped unaided with twins, malpresentations, three antepartum haemorrhages, and a cord prolapse. Exceptionally, one case was delivered by 'Forceps (Mr. Miller) for delay in 2nd. stage'.[85] By 1890 the casebook evidence implies that, in contrast to the two earlier years studied, the house surgeon had both more and different skills and experience. In addition, he had a larger supervisory role over the medical students, they in turn being expected to identify problems for the house surgeon. This indicates an increasing stratification in the practice of midwifery by the medically-qualified and others.

In contrast to 1870, when all the traced and surviving house surgeons apparently entered general practice, in 1890 only six at most did so, often after acquiring additional qualifications. Only William Paterson followed the custom of 1870, and established himself in Langside, Glasgow, apparently without further training. He was still there in 1921. Williams, Armour, Melville, and Duncan held additional house posts before settling, whilst Armour also took the certificate of the Medical Psychological Association. The three last were Fellows of the Edinburgh Obstetrical

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[83] 1890 SOCB, facing p. 89.
[84] 1890 OCB, case 97 (Prof. Simpson's second quarter) [ARS2] [304/97ss/90so].
[85] 1890 OCB, case 75 (Dr Halliday Croom's quarter) [JHC] [129/75hc/90so].

Society, implying that they continued actively to practise obstetrics, the first two in Edinburgh. By 1901, Fitzgerald was back in Kaitangata, New Zealand.[86]

For four house surgeons, however, their period at the ERMH was part of an upward professional progress. Both Lackie and Fordyce were able, by differing routes, to become consultant obstetricians and gynaecologists in Edinburgh. By the end of 1890 Fordyce had also acted as Assistant to the Professor of Clinical Medicine. He had a period as house physician in the gynaecological wards at the Infirmary, and by 1901 was Assistant Professor in the Diseases of Women and Children. He was also assistant physician at the ERMH, and from 1911-23, the gynaecologist at Leith Hospital. Thereafter he was physician at the ERMH and gynaecologist at the RIE. From 1894 he published regularly on gynaecological topics. In 1929 he was a founder-member of the Royal College of Obstetricians and Gynaecologists.[87]

Initially, Lackie apparently followed an older career path. On leaving the ERMH in 1890 he became for a time clinical assistant at the Royal Asylum, Montrose, and then entered general practice in England. However, by 1896 he had also been Assistant to the Professor of Clinical Medicine, and both house and resident physician in the gynaecology wards at the RIE. By 1901 he was assistant physician at the ERMH, and by 1921 he was physician there. Between 1896 and 1912 he published papers exclusively on obstetric topics. Both were (unsurprisingly) Fellows of the Edinburgh Obstetrical Society.[88] Both Fordyce and Lackie were able to capitalise on their early academic success in midwifery to make contacts and seek posts that kept them in Edinburgh and allowed them to advance professionally. Both publicised that success through their academic papers. Their careers illustrate the way in which midwifery experience at the ERMH had changed from being a useful skill to being the basis for a profession. A house surgeoncy could now be a professional step forward rather than a means of consolidating a student skill.

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[86] LPMD, 1890, 1896, 1901, 1906, 1913.
[87] LPMD, 1890, 1896, 1901, 1906, 1913, 1921; Boyd, *Leith Hospital 1848-1988*, p. 66.
[88] LPMD, 1890, 1896, 1901, 1906, 1913, 1921; Boyd, *Leith Hospital 1848-1988*, p. 66.

Turner and Gillespie both began to develop senior medical careers, but outside obstetrics. Turner eventually became Medical Electrician at the Infirmary, and Lecturer on Medical Physics at Surgeons' Hall, publishing both books and papers on the subject. In 1894 Gillespie became Freeland Barbour Fellow at the Royal College of Physicians, and by 1896 was medical registrar at the RIE, and lecturer in Materia Medica and Therapeutics at Minto House. He too published widely, on digestion, but died in 1904.[89]

In 1890 the ERMH offered its house surgeons on average 42 experiences, a small increase on the 38 of 1870. However, the nature of that experience was very different. In contrast to 1870, in a quarter of the cases they delivered some intervention in labour was used, typically forceps to shorten the second stage. This distinguished them from the students, who generally were forced to call for superior assistance. The overall experiences of the house surgeons in 1890 illustrate the changes that had taken place in the previous 20 years in the medical approach to childbirth, in doctors' careers, and in the hospital itself. The regular intervention at delivery that they provided indicates a major change in the understanding of the medical role in obstetrics; the biographical data on Fordyce and Lackie illustrate the development of obstetrics as a medical specialty. Finally, the calibre of the appointees to house surgeoncies indicates the improvement in status in the medical world of the ERMH itself. However, whilst the casebook data for 1890 confirm other hospital material regarding house surgeons in their period and area of service, they are at variance with the apparent role of the house surgeon in a difficult delivery. The original Rules, and those revised in 1899 and 1905, reiterate that house surgeons were only to intervene under the direction of a senior: the casebook data provide no direct evidence of this, but suggest the house surgeon intervened independently of specific advice. This illustrates a possible area of conflict between the changing practices and demands of obstetric education, and the management of a charity, dependent for its survival on its good reputation among potential subscribers.

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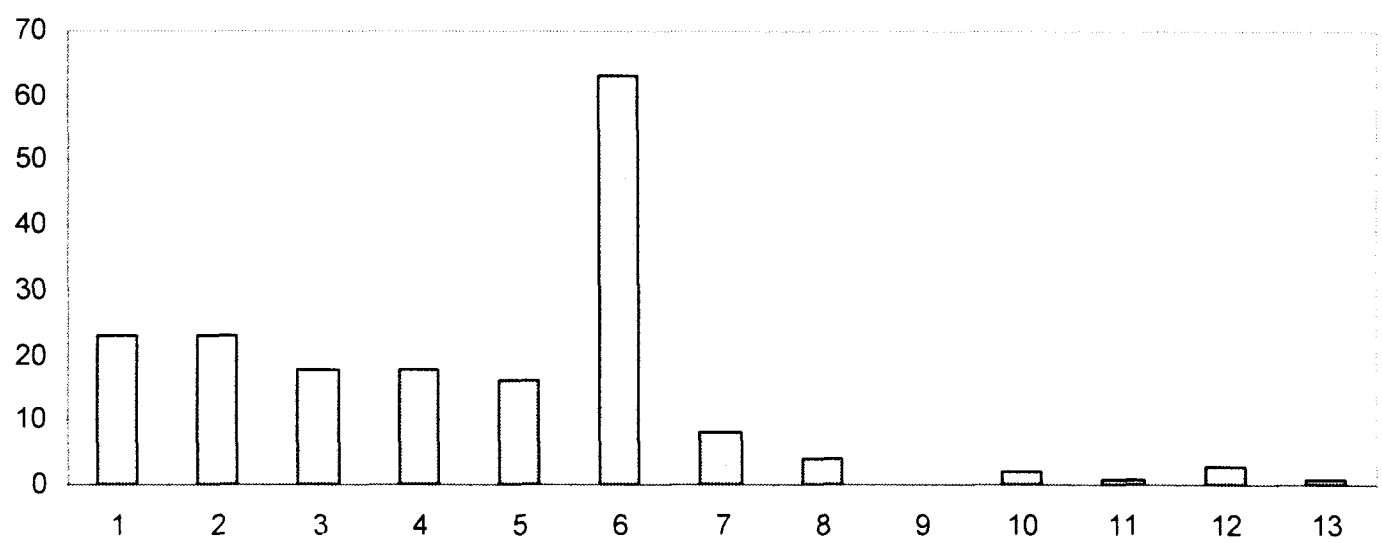
[89] LPMD, 1890, 1896, 1901, 1906, 1913, 1921.

5.5.3 Medical Students

By 1890 major changes had taken place in the training medical students received at the ERMH. 180 medical students now attended for their practical midwifery experience, a massive increase on the 27 of 1870, and the 38 of 1850. Of these 37, or 21%, were not matriculated students.[90]

Figure 5.14
Distribution of Total Appearances of Medical Students at the ERMH, in Number of Cases, 1890



Source: ERMH Indoor and Outdoor Casebooks, 1890
This figure shows the number of students (vertical axis)
who attended different numbers of cases (horizontal axis)

Figure 5.14 shows the distribution of medical students' total appearances in the casebooks in the year. No student made more than 13 appearances, whilst slightly more than half (54%) appeared less than six times, a considerable fall in recorded experience from 1870, and less than the minimum requirement for graduation. Only 11% made more than six appearances. It can be suggested that this failure resulted from the great number of medical students attending during 1890 (180), in contrast to 38 in 1850 and 28 in 1870. The apparent decline in midwifery experience is more evident when the nature of their experience is examined. Three-quarters of the students attending did not deliver six babies, the average being 3.35; only 9%

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[90] That is, they do not appear either in the Comrie files (Special Collections, Edinburgh University Library) or the files of Edinburgh University medical graduates generated from matriculation records. They include the first two female medical students to attend the ERMH, Margaret K. Barclay and Grace R. Cadell.

achieved six deliveries, and only 3% exceeded that number. A sizeable group (13%) appear only as witnesses.

This decline in practical midwifery experience amongst medical students raises a number of questions, the principal being whether the casebook data is reliable. The Examination schedules for 1890, 1891 and 1892 have been searched for those of known ERMH students who recorded their practical midwifery experience. Fourteen such schedules were found, 12 of which give the number of cases attended. In seven, the number of cases on the schedule tallies with the number of appearances recorded in the casebooks. Two students recorded fewer cases than are ascribed to them in the casebooks. For example, Henry Benson claimed 12, whilst the casebook records 13, including nine deliveries. Some confusion may have arisen over the meaning of 'case'. The house surgeons of 1887 clearly thought that being present at, or witnessing a delivery, constituted a case, as they completed a student's certificate: '[h]e was present at the delivery in ***Three Indoor*** cases .... He delivered and had the entire management in ***Three Outdoor*** cases ***[Total 6 Cases]*** ....'[91] John Anderson claimed '6 cases', although from the casebooks he conducted five deliveries and witnessed seven. Likewise, Thomas Brierley claimed to have attended '12 labours Royal Maternity Hospital' when he is entered as carrying out six deliveries, although it is plausible that he witnessed the remaining six Indoors and it was not recorded.[92] No student was likely openly to declare that he had not achieved the minimum requirement for entry to the final examination, and some merely recorded that they had attended the hospital.[93] However, three students declared that they had attended six cases, when the casebook evidence is of a lower number.[94] Overall, there is insufficient evidence to decide which record is at fault, but there is sufficient to conclude that there had been a remarkable downturn in the amount of practical experience in midwifery obtained by medical students.

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[91] Hospital certificate of Robert Thin, 1887 [LHSA, LHB 3/38/23].
[92] 1891 Medical Examinations: Anderson, Brierley; 1892 Medical Examinations: Benson.
[93] See, for example, 1890 Medical Examinations: Duncan; 1891 Medical Examinations: Bienemann.
[94] 1891 Medical Examinations: Currie, Eurich, Jack.

It must also be asked whether their time at the hospital constituted all the students' experience, or whether they attended two or more courses, or additionally accompanied a registered practitioner. Examination of the schedules in the above years has found only one student who declared that he had received practical midwifery experience from two sources. James Fitzgerald, house surgeon from February to May, declared that he had done his practical midwifery in the autumn of 1889, attending nine cases at the ERMH, and six at the Marshall Street Dispensary.[95] Overall, this scanty evidence does suggest that the ERMH records do record the entire practical midwifery experience for the majority of medical students attending in 1890.

In addition to the six cases, medical students were required to have 'attended for at least 3 months the practice of a midwifery hospital in which instruction is regularly given'.[96] The casebooks provide little direct evidence of this, recording only the dates on which deliveries were attended. Thus, from the casebooks, Benson was present for three weeks, and John Anderson for four. However, Anderson and others claimed '3 mths clinique'.[97] This is evidently an area of experience not revealed in the casebooks. Nonetheless, whilst clinique cases are not identified in the casebooks, evidence for continued teaching, although not by whom, comes from complaints from the Ladies' Committee between 1881 and 1891.[98]

The nature of the experience the medical students received was not greatly different from that of 1870, although they appear to have had less responsibility as well as fewer cases. Nonetheless, an apparent increase in sick patients, whose care was described in the Special and Ordinary Casebook, gave students a greater role in their care, although this may be the result of a change in documentation rather than treatment. For example, in March 1890 Mrs Main 'called at the hospital, complaining of swelled legs and feet. She desired that the student whose duty it might be to

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[95] 1890 Medical Examinations: Fitzgerald.
[96] *Edinburgh University Calendar*, 1890-1, pp. 354-6.
[97] 1890 Medical Examinations: Paterson; 1891 Medical Examinations: Anderson, Eurich, Jack.
[98] In 1881 they urged that inmates of the married women's ward were 'not to be used for teaching .... in the presence of pupils'; in 1891 they complained that patients were unnecessarily exposed during teaching. (DMERMH, 3 March, 1881, 6 July 1891).

deliver her should see her a few days previous to her confinement. A student was immediately detailed to attend her', that is, prior to the birth of her children.[99] Students were also nominally in charge of their cases postnatally. In the case of Mrs Mary Henderson Armstrong, who sank into a uraemic coma, 'Bismuth was given by the student in charge to relieve vomiting'. Two days after delivery, '[t]he student in charge .... reported the patient to be suffering from pleurisy. He was sent back by the House Surgeon to draw off patient's urine and examine it.' Finally, quite possibly after staying overnight, '[t]he student in charge sent a message to Maternity Hospital at 7am asking for assistance'.[100] Other evidence of postnatal attendance by students can be found in the Outdoor casebook.[101]

Table 5.12
The Number and Type of Medical Students' Experience at the ERMH, 1890

	Indoor	Outdoor	Total
Total Medical Student Deliveries	0	526	526
Total Deliveries accompanied by Senior	0	1 (5)	
Total Students who Witnessed Cases (includes duplicate cases) [a]	1	293	294
Total Students who Witnessed Delivery by Senior	1	67	68

Source: ERMH Indoor and Outdoor Casebooks, 1890

[a] That is, cases witnessed by more than one medical student.

Table 5.12 shows the recorded experience, in terms of supervision and teaching, of medical students at the ERMH. Medical students conducted 526 deliveries. Only once was a student, Miss Cadell, accompanied by a doctor in a manner recognisable from 1870. In a further five cases the house surgeon is recorded as witnessing a student delivery, but in each the patient had suffered a miscarriage, and the doctor was called to ensure the uterus was empty.

The large number of students increased the numbers of deliveries witnessed, and, as shown, the examination schedule evidence suggests that these were counted as cases,

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[99] 1890 SOCB, pp. 73-5.
[100] 1890 SOCB, p. 61.
[101] For example: Baby Short, '[c]hild, a weakling, had Spina Bifida, died in 4 days ....' (1890 OCB, case 54 CEU [275/54u/90fo]); Baby Marr 'developed Gonorrhoeal ophthalmia on 4th day - treated in house - eyesight lost ....' (1890 OCB, case 47 JHC [101/47hc/90so]).

at least by some.[102] A student delivered on his own in only one-fifth of student cases, compared with nine-tenths in 1870.[103] In addition, 68 students, approximately a third, witnessed difficult deliveries by their seniors. For 48 students these were instrumental deliveries by the house surgeon of 24 patients whose labours had become protracted. Ten students saw deliveries by more senior doctors. With one exception these were Outdoor cases, and again represented problems with assigned patients. The exceptional case may represent some family influence. William Fitzgerald was present with his brother James, the house surgeon, when Mrs McLachlan, a patient with a known rickety pelvis, was induced and delivered by Berry Hart.[104] Additionally, two students saw Prêvot's operation, two observed podalic version, and one was present at caesarean section. The operators were either the assistant physicians, Berry Hart or Underhill. Medical students were more likely to see intervention at delivery than in 1870, but usually this was the result of changed management of cases, rather than increased educational effort.

Table 5.11 (in Section 5.5.2) shows the students' experience in terms of the presentation problems they encountered at deliveries. The great majority of cases delivered by them, as with the house surgeons, were considered normal. Both medical and midwifery students were generally expected to deliver breech presentations and twins unsupervised. In this there is little difference between 1890 and the practice of the hospital in 1870. However, the 1890 students showed less independence in their management of third-stage problems. Only in four of the 19 cases when the placenta or membranes were retained, did the student in charge fail to call the house surgeon, compared with half in 1870. However, they did record coping with nine instances of postpartum haemorrhage without assistance, employing ergot and Credé's manoeuvre once each. Overall, in 1890 the medical students had much less immediate practical experience of midwifery. Further, their practice was now distinguished from that of their immediate seniors in a way in which it had not been in the two previous years studied. In crude terms the principal difference between the

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[102] For the widespread nature of this practice, see Loudon, *Death in Childbirth*, p. 191.
[103] In 1890 they delivered on their own in 94 out of 526 cases; in 1870 they delivered alone in 182 out of 202 cases.
[104] 1890 ICB, case 38 DBH [064/38bh/90fi].

practice of the house surgeons and that of the medical students was the use of forceps. However, the implication that qualification alone brought with it an entitlement to use them was an over-simplification. Whereas in the two earlier years studied, the house surgeon had been distinguished from the medical students solely by his larger investment, by 1890 this was not so, as will be shown. In 1890 house surgeons were evidently selected from a range of applicants, were superior in their medical education to the majority of medical students, and presumably their use of forceps had been preceded by some training.

To examine the social circumstances of the medical students, and their future careers, and to contrast these with those of the house surgeons, a sample of five 'high-scoring' students and five 'low scoring' has been taken, although there is less variation in the number of cases than in former years. To these have been added the two women medical students, and two men, one of whom was successful in his application for a house surgeoncy in 1893, and one who was not.

Table 5.13
ERMH Medical Students Selected for Further Examination, 1890

Name	Number of Experiences	Career
Benson	13	General practice
J. Anderson	12	General practice
Cameron	12	Army
Crowley	12	Not traced
Heaney	11	Not traced
Miss Barclay	6	Married a GP
Miss Cadell	6	Physician, Women's Consulting Rooms
Petrie	6	Travelling
Watt	5	Various Assistantships/Army
W. Anderson	2	General practice
Currie	2	General practice
Hermon	2	General practice
Jack	2	General practice
Macrae	2	I.M.S.

Source: ERMH Outdoor casebooks, 1890; Medical Register and Directories

Two students in the entire group were untraced. Approximate ages are known for nine, and their ages ranged from 21 to 26. Variation in age now resulted from taking a previous degree, rather than apprenticeship, as in 1850. The entire group took M.B. and C.M., although the women were also Licentiates of the Faculty of Physicians and Surgeons of Glasgow. To this point, students and house surgeons seem very similar, but when years of registration are compared (Table 5.14), the extra seniority of the house surgeons can be seen.

Table 5.14
Years of Registration with the GMC
of House Surgeons and Medical Students at the ERMH, 1890

	1888	1889	1890	1891	1892	1893	1894	1895	Not Traced
House Surgeons	4	1	6	0	0	0	0	0	0
Medical Students	0	0	4	5	2	0	0	1	2

Source: Medical Registers, 1888-95

The careers of the selected students support the conclusions about 1850 and 1870: that there is little obvious association between enthusiasm for midwifery as a student and future career. Three students were traced from the 'high' group, of whom two became GPs, whilst the third joined the RAMC. In the 'low' group, four became GPs, whilst one joined the Indian Medical Service. Margaret Barclay took a further degree in Brussels, then married a GP in Edinburgh. Reginald Petrie, who was appointed house surgeon in 1893, spent a short period as a GP before being described as 'travelling' for the rest of his professional life. Neish Park Watt, who was unsuccessful, had a number of junior posts. He then served as Assistant Medical Officer to the Scottish National Red Cross Hospital in the 'Transvaal war', and in 1906 was a captain in the Army Medical Reserve. Only Grace Cadell maintained an interest in women's health. After a post as registrar at the New Hospital for Women, London, she became physician at the free consulting rooms for women in Leith.[105]

By 1890 there had been major changes in the education received from the ERMH by its house surgeons and medical students. The biographical data show that by 1890 house surgeons were not usually senior students, but were registered doctors, possibly in their second house surgeoncy. Thus, they were older than the students

who attended, had made a definite decision to attend the hospital, and some were better able to make use of the contacts that they made to advance themselves professionally. Further, the casebook data show increasing difference between house surgeons and students. House surgeons were now judged to be capable of intervening in slow labours, without consultation with their seniors, in a way that was not considered 20 years before. They were distinguished from medical students by their ability to deliver with forceps.

The casebook data also show a marked overall decline in the number of cases and responsibility taken by students, in contrast to the earlier years studied, including evidence that some students failed to reach the minimum number of cases necessary to qualify. Loudon has remarked on the decline in the number of student cases and interest in midwifery that followed on its becoming a compulsory subject for registration in England.[106] Although midwifery had been a compulsory element in Edinburgh since 1826, the ERMH data shows a similar decline, and, in the sixfold increase in student numbers since 1870, combined with only a doubling in the number of patients using the hospital, suggests a reason for it.

Students were also required to attend at least 100 lectures in midwifery, and all recorded the course attended in their examination schedules. The contents of such lecture courses, and the ensuing written and oral examinations, suggest that there had also been changes in the understanding of labour itself, now seen as more likely to be hazardous, and certainly more defined, and that an increasingly academic approach was being taken towards midwifery.[107] Thus, while the academic and problem-solving content of the course had increased, the practical experience had declined since 1870, both in amount and in responsibility. Although in all the years the students were primarily completing the requirements for the final examinations, in

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[105] LPMD, 1896, 1901, 1906, 1913, 1921.
[106] Loudon, *Death in Childbirth*, pp. 191-2.
[107] The lecture notes taken by George Mackay (Heads of Lectures on Midwifery etc. Delivered by J. Y. Simpson M.D. .... during the Winter Session 1850-1 [LHSA, LHB MAC GD1/1/3-4 A&B]) can be compared with those taken by Dr E. Burnet in 1905 (Lectures on Midwifery Delivered by Professor Sir Halliday Croom, 1905-6, [LHSA, LHB MAC GD1/1/7]), and the oral questions of 1891compared with those of 1870 (1870 Medical Examinations: Wood; Kennedy; 1891 Medical Examinations: Eurich, Jack).

1890 the impression is given, possibly by weight of numbers, that that was all that was intended. The evidence of the ERMH casebooks suggests that by 1890, the quality of midwifery instruction for medical students in Edinburgh, so praised by Loudon in its contrast to London practice, had diminished in the face of increased numbers and an increasingly study-based course, a view expressed vividly by Robert Milne Murray in his 1901 address to the Edinburgh Obstetrical Society.[108]

5.5.4 Midwifery Nurses

In 1890, 57 midwifery nurse pupils attended the ERMH, in quarterly sets of between 10 and 14. This can be seen clearly in Figure 5.15, which shows their appearance by week. The existence of quarterly sets by 1892 is confirmed by the Register of Nurses, introduced by the new matron, Miss Edward. This records the details of nurses attending the hospital according to their time of intake.

The prompt arrival and departure of the 1890 groups also suggests the existence of courses. However, it can also be seen that in three of the quarters, a previously-trained midwifery nurse was retained to help with the work of the hospital whilst the new group was settling in. In the January group, Nurse McQueen apparently stayed for a further four weeks, whilst in the May-July group, Nurse Wilson remained. Mrs Hall of the November 1889-January 1890 group was later appointed Staff Nurse, and fulfilled part of the function of the extra nurse in the November 1890 group. Comments added to individual entries in the Register suggest that the practice continued: Kate Leslie Scott, of the February 1893 class, 'stayed another quarter .... very good'.[109]

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[108] Loudon, *Death in Childbirth,* p. 192-3; the address is contained within Margaret Milne Murray *The Practical Training in Midwifery of the Edinburgh Medical Student: An Appeal to the Senatus of the Edinburgh University, the Directors of the Royal Maternity Hospital, and to the Physicians of that Institution,* (printed privately, 1908), pp. 1-6.
[109] ERMH Register of Nurses, 1892-1928, February 1893 class.

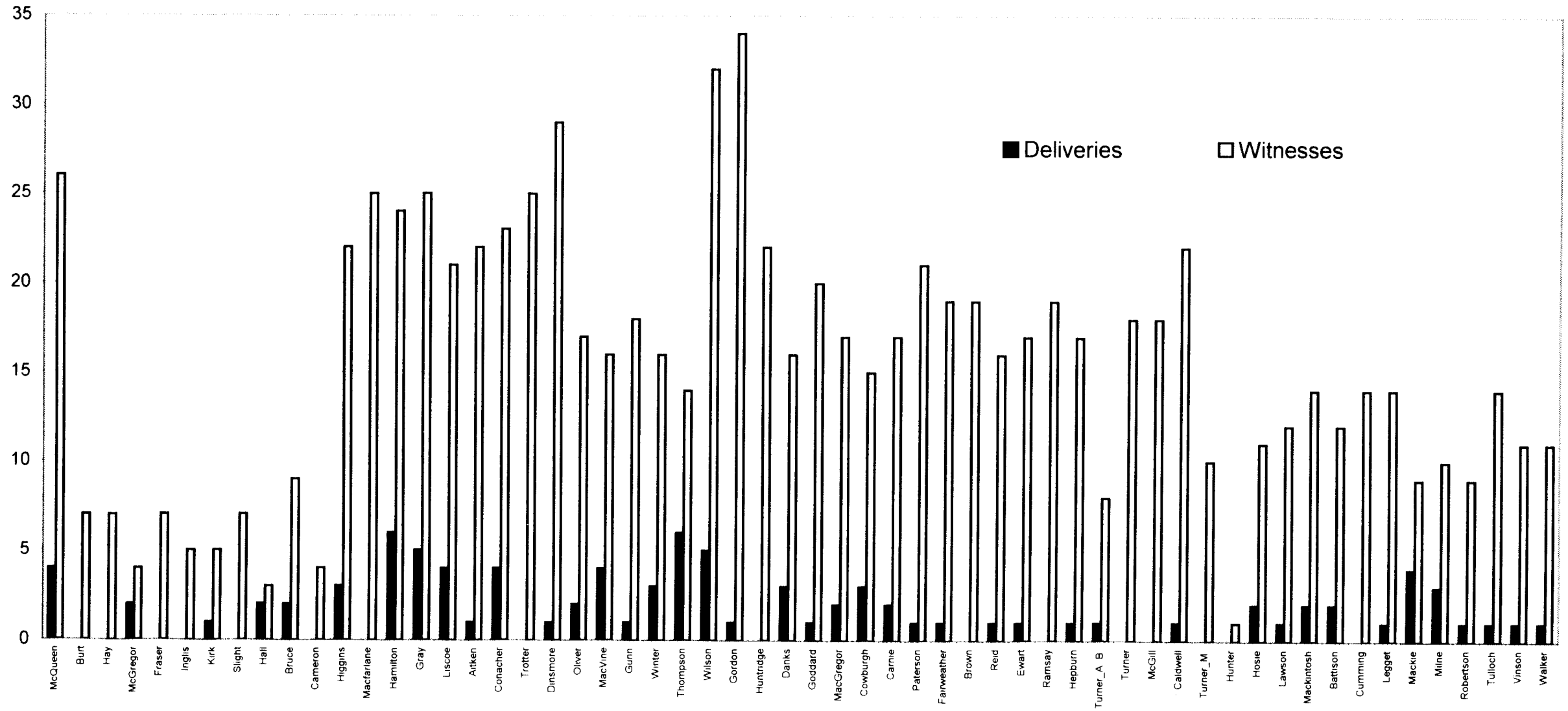
Figure 5.15
Appearances of Midwifery Nurses at the ERMH, by Week, 1890

McQueen	********. . . . .
Burt	*****. . . . .
Hay	*****. . . . .
McGregor	***.*. . . . .
Fraser	*.***. . . . .
Inglis	*.***. . . . .
Kirk	*.***. . . . .
Slight	*.**. . . . .
Hall	*..*. . . . . *..*. . . . .
Bruce	.***. . . . .
Cameron	.*.*. . . . .
Higgins	. . . . .**********. . . . .
Macfarlane	. . . . .**********. . . . .
Hamilton	. . . . .*.**********. . . . .
Gray	. . . . . **********. . . . .
Liscoe	. . . . . **********. . . . .
Aitken	. . . . . ********.***. . . . .
Conacher	. . . . . ****..******. . . . .
Trotter	. . . . . **. . . . . ******.*.*. . . . .
Dinsmore	. . . . . *..********. . . . .
Oliver	. . . . . *********. . . . .
MacVine	. . . . . *******.**. . . . .
Gunn	. . . . . *****.*******. . . . .
Winter	. . . . . **.******.**. . . . .
Thompson	. . . . . **********.*. . . . .
Wilson	. . . . . *******.**********. . . . .
Gordon	. . . . . *******.****. . . . .
Huntridge	. . . . . ******.*****. . . . .
Danks	. . . . . *****...****. . . . .
Goddard	. . . . . ****.*******. . . . .
MacGregor	. . . . . ***..***.***. . . . .
Cowburgh	. . . . . **.**.******. . . . .
Carnie	. . . . . ******.****. . . . .
Paterson	. . . . . **********. . . . .
Fairweather	. . . . . ********.****. . . . .
Brown	. . . . . *.********.**. . . . .
Reid	. . . . . *.*.*****..**. . . . .
Ewart	. . . . . **********. . . . .
Ramsay	. . . . . **********.*. . . . .
Hepburn	. . . . . ****.*.**.**. . . . .
Turner A. B.	. . . . . ****..***.*. . . . .
Turner	. . . . . **.*****...*. . . . .
McGill	. . . . . ****.****.*. . . . .
Caldwell	. . . . . **.********. . . . .
Turner M.	. . . . . **..*****. . . . .
Hunter	. . . . . *. . . . .
Hosie	. . . . . ********
Lawson	. . . . . ********
Mackintosh	. . . . . ********
Battison	. . . . . *******
Cumming	. . . . . **●*****
Legget	. . . . . *******
Mackie	. . . . . *******
Milne	. . . . . *******
Robertson	. . . . . *******
Tulloch	. . . . . *******
Vinson	. . . . . *******
Walker	. . . . . **.***
'Nurses'	. . . . . *. . . . .

Source: ERMH Indoor and Outdoor casebooks, 1890

Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

Figure 5.16
Numbers of Deliveries Carried Out and Witnessed by Midwifery Nurses at the ERMH, 1890



Source: ERMH Indoor and Outdoor Casebooks, 1890

The recorded experience of individuals can be seen in Figure 5.16, the participants being in the same order of appearance as in Figure 5.15. The increased numbers of experiences resulting from a longer stay are clearly visible in the records of Nurses McQueen and Wilson. However, it should be noted that Mrs Gordon achieved a higher number of cases within her three months' stay. Nurse Trotter seems to have changed set, possibly because of illness, while Nurse Hunter attended one case only. The experiences of Nurses Amy and M. Turner are unclear, as the record does not always differentiate between them. Nurses also suffered from the effects of student over-crowding and the hospital's belief that a witnessed delivery could be considered as a case, although prior to the creation of the CMB, they did not need to achieve a set number of cases. It can be seen that, of those who were present for a full three months in 1890, the typical nurse witnessed 15 to 20 deliveries, but carried out the delivery themselves in only one or two cases.

Table 5.15
Number and Type of Midwifery Nurses' Experience at the ERMH, 1890

	Indoor	Outdoor	Total
Total Midwifery Nurse Deliveries	3	94	97
Total Deliveries accompanied by Senior	0	0	0
Total Cases Witnessed (includes duplicate cases)	0	901	901
Total Students who witnessed Delivery by Senior	0	79	79

Source: ERMH Indoor and Outdoor casebooks, 1890

The experiences of the nurses in terms of teaching are set out in Table 5.15; their experiences at delivery are listed in Table 5.11 (Section 5.5.2). When they carried out their deliveries, it was almost always Outdoors, and in the company of another nurse. Only once did a nurse apparently deliver in the presence of medical students.[110] On three occasions Mrs Hall delivered Indoor patients: all three occurred after her appointment as Staff Nurse. Supervised nurse deliveries were no longer recorded in the casebooks, but the presence of the category 'Delivered under the Superintendence of the House Surgeon' on hospital certificates indicates that it

[110] 1890 OCB, case 64 DBH [111/64bh/90fo].

continued.[111] The vast majority of deliveries carried out by the nurses were unremarkable. However, whilst the numbers are very small, a greater percentage of the nurses' cases were twin deliveries, although they delivered fewer breech presentations.[112] They had no recorded haemorrhage or third stage problems. Overall, the impression given is that when the nurses carried out deliveries, they were as capable as the medical students, and given similar responsibilities.

Nurses witnessed 39 complicated deliveries, carried out by either the house surgeon or a more senior doctor. The great majority of the house surgeon cases were forceps deliveries, typically justified by uterine inertia, delay, or rigid perineum. Two nurses saw caesarean section, and two Prêvot's operation; two saw a uterine rupture, and two saw Barbour deliver by version after forceps delivery had failed. Two saw Milne Murray deliver a live child by forceps for disproportion.[113] In each instance the nurses had already been attending the patient: there was no implication that a class (or part of one) was being shown an unusual outcome, as was seen Indoors in 1870, and in this they were treated similarly to the medical students.

However, the operators in the vast majority of the cases that the nurses witnessed were not qualified doctors, but medical students. Nurses attended 73% of medical student deliveries, in contrast to 1870, and their presence had become so expected that Miss Barclay could complain that '[n]urses not present'.[114] This suggests that a new role for them had developed. It can be inferred that they now provided some domiciliary nursing, and ensured that the hospital requirements on antisepsis were met.[115] When so many medical students attended so few deliveries each, the nurses also represented the hospital. It is significant that it is they, and not the medical students, who appear in the photograph of Professor Alexander Simpson and the

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[111] See, for example, the certificates of Mrs Jane Todd, 1885, Miss Mary Morrison, 1886-7, (footnote 78) and also that of Miss Lucretia Hewitt, 1901. (A photocopy of her hospital certificate (dated 31 July 1901) is in the care of the Museum of Edinburgh, Huntly House).
[112] 2.2% of the nurses' cases were twins, compared with 0.8% of the students'. However, 3.4% of the students' cases were breech, compared with 2.2% of the nurses' (see Table 5.11).
[113] 1890 OCB, case 52 JHC [106/52hc/90so].
[114] 1890 OCB, case 172 DBH [219/172bh/90fo].

November 1890 set, and that it is captioned 'Edinburgh Royal Maternity and Simpson Memorial Staff' (Illustration 5.3, at the end of this chapter).

In addition, the small increase in sick patients and the stricter enforcement of bedrest meant that there was a greater need for nursing care Indoors, now provided by the nurse pupils.[116] When Mrs Gordon's experiences are examined in detail, it can be seen that whilst she was regularly recorded over a period of 76 days, her presence is not recorded in the Outdoor casebook in four discrete periods of five to nine days, implying that she was working Indoors. Overall, she may have worked Indoors for 26 days, or approximately a third of her recorded time. Similarly Nurse Wilson, of the same set, was twice absent for short periods. The absence of Nurse Wilson for eight days again, at the start of her 'staying-on' period, combines with the apparent lack of nurses Outdoors[117] to suggest that the management liked an experienced nurse within the hospital, and also that there was some form of induction for new pupils.

It can be argued that the use the hospital made of its midwifery pupils as nurses for its sick patients, and assistants at medical student deliveries, reduced their effectiveness as midwives, and that many did not intend independent practice. However, this is not borne out by the future careers of those traced. Of those previously mentioned and trained in 1890, only Helen Stenhouse Wilson was still in practice in 1916, enrolling with the Central Midwives Board for Scotland [CMBS] while she was working in Duns.[118] Jane Todd, whose certificates are dated 1885, evidently emigrated and continued to practise in South Dakota.[119] Other women from approximately this time period, whose details are recorded in the Register of Nurses, and who sought enrolment in 1916, also appear to have worked as midwives and

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[115] The Special and Ordinary casebook refers to nursing care being given through the dispensary. For example: '[a]fter the birth of the child and before the nurses had left the house...'; '[a]fter delivery the patient was watched for many hours...'; (1890 SOCB, pp. 61, 97).
[116] Amongst the sick Indoor patients treated that year were Mrs Anderson and Mrs McGlincey, severe blood loss from placenta praevia; Mrs Cumming and Mrs Thompson, uncompensated mitral stenosis; Georgina Pettigrew, six weeks' stay after Porro's operation; Mrs Smith and Mrs Speirs, eclampsia.
[117] This phenomenon occurred at the beginning of each set. In February and July, no nurses were recorded for six days; in May none were recorded for 10, whilst in November it was 14 days.
[118] She applied for inclusion on the Midwives Roll for Scotland by right of her ERMH certificate.

considered enrolment a necessary professional move. Jane Groat of Inverness trained in 1891 and was 1636 on the CMBS Roll. Catherine Booth, née Davie, of Arbroath, trained in 1895 and became CMBS 2729.

However, for some pupils the increased experience of nursing sick parturient women may have been professionally desirable. Mary Morrison, who trained at the ERMH in 1886-7 after eight years as 'Head of a surgical charge' in the Royal Infirmary, sought to become Matron of Dunoon Cottage Hospital in 1890: possibly she saw midwifery as an additional professional skill to add to her portfolio.[120] Lucretia Hewitt, who trained in 1901, consistently advertised herself as a Sick or Ladies Nurse in Edinburgh, although she used her ERMH certificate to apply for inclusion on the Midwives' Roll for England and Wales in 1904. Her surviving equipment suggests that she worked principally with mothers and babies, since it includes a portable scale and delivery gowns.[121] Prior to 1894, lecture certificates from individual ordinary physicians were issued, some of which have survived (see Illustration 5.3, at the end of this chapter). This practice ceased under pressure from the British Medical Association, although the lectures continued.[122]

The experience of the midwifery nurses in 1890 also shows changes in the management of childbirth, and particularly the puerperium. Greater medical emphasis was placed on nursing, on hygiene, and on bedrest, and this contributed to the medicalisation of the formerly social period of lying-in. However, the nurses' experience remained rooted in the practical: although they carried out only a small number of deliveries, they had many opportunities to observe others in action. Census evidence from 1891 shows that there was little change in the type of woman who trained at the ERMH. Ten nurses are recorded other than the Matron and Agnes Hall, of whom, as in 1871, the great majority were or had been married. Only two

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[119] LHSA, LHB MAC GD1/35/2.
[120] However, the papers relating to her include six letters of reference from notable Edinburgh surgeons, but no obstetricians. [LHSA, LHB GD1/77/1-9].
[121] Her equipment, photocopies of her certificate and correspondence with the CMB and her photograph in uniform are in the Museum of Edinburgh, Huntly House, Canongate, Edinburgh. She advertised in the Edinburgh Post Office Directories from 1905.
[122] MBMERMH, 16 July, 1894.

were single. Again, their average age was 33, ranging from 24 to 44, and most were Scots, although two were English.[123]

By 1890 there had been major changes in the organisation of the hospital. As described in Chapter 2, section 2.5.1, the periods of attendance for senior doctors had been defined, with four attending over the year, in separate quarters, supported by assistant physicians. This encouraged a closer relationship with the junior doctors, who were also employed by the quarter, and thus the development of a distinct qualified medical group. This was reinforced by changes in management at delivery evident in the casebooks, which, in contrast to earlier years, showed a difference between the practice of house surgeons and students. House surgeons were also now clearly distinguished socially from the medical students, in terms of their age and qualification. With increasing interest in the dangers of labour went an increase in student supervision and guidelines for intervention. The ensuing stratification of staff and treatment meant it was possible also for the medical students to conceive that normal deliveries were the preserve of midwives and students, and to take a belief in increased medical intervention with them into general practice, unsupported by education or training. Based on ERMH evidence, one could certainly suggest that the emphasis on increased theoretical knowledge was not matched by increased practical experience, and may even have detracted from it. At the same time, the divergence in role and status between midwife and doctor degraded the understanding of the management of normal labour. By 1890 the education and training available to junior doctors, medical students, and midwives at the ERMH illustrated the increasing medicalisation of childbirth, and the gradually differentiating roles of the attendants.

5.6 Evidence from 1912

In 1910 the quarters into which the hospital year was divided were re-organised, to run from January to March, April to June, July to September, and October to December. This means that the data on hospital staff taken from the 1912 casebooks represents a full period of service, with only the house surgeons overlapping into 1911 and 1913.

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[123] RGS, *1871 Census of the City of Edinburgh,* Registration District 685[4], Enumeration Book 75.

5.6.1 Senior Doctors

In 1912 eight senior doctors attended the hospital, being the physician and assistant physician for each quarter. In all they attended 39 cases, although these were not evenly distributed throughout the year. Haultain and Lackie saw 16 from January to March, whilst Halliday Croom and Haig Ferguson attended only five, including two teaching cases, in the period from October until the end of the year. Each pair acted only within their own quarter, and there are no records of senior colleagues being called in to assist in particularly difficult or unusual cases.

The distribution of cases between physician and assistant physician varied between the pairs. Haultain and Lackie attended eight cases each, Ballantyne attended six of the nine which occurred in his and Nicholson's quarter, whilst Barbour attended eight of the nine which occurred in his and Fordyce's quarter. This does not appear to result from any lack of experience: Fordyce had been Barbour's assistant physician since 1904, whilst Nicholson, the most recent appointment, had been in post since 1906. In contrast to 1890, the distribution of cases seems less directly related to the number of other posts held. For example, in addition to his ERMH post, Haultain was also a physician at the Deaconess Hospital, Assistant Gynaecologist at the Infirmary, an examiner to the RCPE, and President of the Edinburgh Obstetrical Society. Lackie, who also had eight cases in their quarter, held two lectureships at the School of Medicine, and was an examiner. Both Barbour and Fordyce appear to have had busy schedules. Barbour held two physicianships, at the Infirmary and the ERMH, lectured in gynaecology at the university, and was an examiner for the RCPE. Fordyce, his assistant physician, held similar posts at Leith Hospital and in the gynaecology wards at the RIE, and was consultant gynaecologist to the Edinburgh Medical Mission Training Institution. In addition, he held two lectureships at the School of Medicine. Halliday Croom, by now Professor, was also consultant gynaecologist at the Infirmary and to the Fountainbridge/Western Dispensary. Haig Ferguson, his assistant physician, had a similar post in the gynaecological wards of the Infirmary, and was also Physician at Leith. He also held three lectureships at the School of Medicine. The impression is that the ERMH now

shared its senior doctors, less with lecturing, than with other hospital or dispensary posts.

The cases that the senior doctors attended were complicated and unusual. All involved the use of instruments or manipulation. However, this was no longer their exclusive territory: house surgeons carried out five destructive operations to the seniors' four, and twelve internal versions to the seniors' five. Eight of the ten inductions of labour were also carried out by house surgeons, although Ballantyne induced abortion in a case of hyperemesis gravidarum. The two women induced by Barbour were both exceptionally sick: one had 'splenomedullary leucaemia',[124] the other pernicious anaemia.[125] As in 1890, the house surgeons also carried out the great majority of forceps deliveries, the seniors delivering nine cases only in this way. Only surgery on the living remained exclusively in the domain of the senior doctors, and they performed nine such operations, including three pubiotomies. Less effort than in previous years seems to have been made to demonstrate complicated cases to junior staff: witnesses were recorded in only nine of the cases involving senior doctors. On two occasions Lackie or Haultain supervised their senior house surgeon as he delivered by version and craniotomy, and in November and December, both Halliday Croom and Haig Ferguson demonstrated forceps delivery to a clinique, a group of medical students. Outwith their teaching regimes, the impression is that senior doctors only attended cases considered exceptional in 1912.

5.6.2 House Surgeons

In 1912 five house surgeons worked at the ERMH, although on four occasions different doctors were briefly present in the absence of the junior house surgeon. Four of the five were Scots. All were Edinburgh graduates, and, in contrast to 1890 and earlier, had, with the exception of Elliott, qualified two or more years previously.[126] Two, Sivright and Ritchie, had previous non-medical degrees. Overall, the impression is that they were older than house surgeons in the past, and had more post-qualification experience, although the way in which they were employed before

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[124] 1912 ICB, case 165 (Dr Barbour's quarter) AHFB [309/165/barb/1912i].
[125] 1912 ICB, case 141 AHFB [285/141/barb/1912i].

coming to the ERMH is not known. The appearances of the house surgeons by week can be seen in Figure 5.17.

Figure 5.17
Appearance of the House Surgeons at the ERMH, by Week, 1912

Sivright	********** . . . . * . . . . .
Olivier	* . . . . .
Hewat	. ** . . . . .
Greenberg	. * . . . . .
Bloom	. . ** . . . . .
Ritchie	. . . . ********** . . . . .
Grant	. . . . . ***.*.*.********** . . . . .
Drennan	. . . . . * . . . . .
Hunter	. . . . . * . . . . . **********
Elliott	. . . . . ***.**.***.**.

Source: ERMH Indoor and Outdoor casebooks, 1912
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

Olivier was the retiring senior house surgeon. Hewat, Greenberg, Bloom and Drennan appear to have been locums, the first three evidently acting for Ritchie, whilst Drennan stood in for Grant. The lower rate of appearance of the house surgeon in his first three months, was the result of his being largely confined to Outdoor practice.

This figure is generated from casebook records of the presence of the house surgeons. They were now expected to stay for six months, three in a junior and three in a senior capacity. The lower number of appearances in the first three months of a House surgeon's appointment illustrate that the junior was primarily responsible for any Outdoor cases requiring medical intervention, but that the majority of Dispensary cases were delivered by pupil midwives. The locums, of whom there were four, were generally used when a new appointee could not start as soon as the post was vacant, and this can be seen in Figure 5.17, in the appearances of Hewat, Greenberg and Bloom before Ritchie starts.[127]

The division of the house surgeon's post, and the doubling of his time in the hospital, indicates changes in the training offered, and the increasing complexity of obstetrics

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[126] Elliott qualified in 1912.
[127] See MBMERMH, 13 April 1896.

itself. The experiences of Alexander Grant and Arthur Hunter, two of the three house surgeons to undergo all their training at the ERMH in 1912, have been examined in more detail. The third, Andrew Ritchie, was evidently late starting his post, as three of the four locums replaced him at the beginning of January.[128] Whilst there is variation in the experience of all the house surgeons, there is nothing to suggest that the two selected are in any way atypical.

Grant started at the ERMH in April. In the first three months he attended eight Indoor cases, six normal deliveries, a case of twins in which the second twin was delivered by forceps, and an abortion. There were 152 Indoor cases in the period. Grant was unsupervised at delivery, but the fact that four occurred in his first two weeks in the hospital implies more that they were to give him additional practice than that he was spending one day a week Indoors, as stipulated in the current Rules, and described in Chapter 2, section 2.5.2. Only once were his cases a week apart. Hunter's experience was very similar. He started in July, and by the end of September had delivered nine Indoor cases, four in the first fortnight, none a week apart. Six were normal, there was one abortion, one forceps delivery, and, in September, the delivery by version of a stillborn infant. There were 157 Indoor cases altogether.

However, both were more active Outdoors. Grant attended 25 cases for the Dispensary and the Leith Branch in his first three months. Of these, 15 had delivered normally, five before the arrival of the attendant. The commonest reason for his visit was a third stage problem, typically anxiety over a retained placenta. On two occasions he was described as removing this manually, under chloroform. On four occasions sutures were required. He attended two ultimately normal deliveries in labour: once to rupture membranes, and once when labour was protracted and intervention anticipated. In this period he also delivered by forceps six times, always for delay. On two occasions Ritchie, his senior, attended forceps deliveries in Leith for him: these cases were a week apart, as stipulated by the Rules, but Grant does not appear in the Indoor record for the corresponding days.

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[128] Despite this, Ritchie had the most Indoor cases of any house surgeon (169).

In his first three months Hunter attended 32 Outdoor cases. Of these, 16 delivered normally, but he was called to deal with the placenta, or, on four occasions, to suture tears. He was also recorded as attending five breech deliveries, but in three cases again he was actually called for third stage problems. Like Grant, he carried out six forceps deliveries for delay. Grant was Hunter's senior, and attended five cases for him, although their dates bore little relationship to when Hunter was active Indoors. On 11 July both were called to a case of retained placenta. Hunter, who was not recorded as present, commented: '[p]lacenta retained & had to be manually removed. Dr Grant'.[129] Again, at an un-dated visit, both house surgeons were recorded as present, Grant taking precedence, but 'Dr Hunter cleaned out 3 months abortion'.[130]

From the evidence of these two house surgeons' ERMH careers, it can be seen that in their first three months the hospital offered them an experience not dissimilar to that of the house surgeons in 1890. They were expected to cope with problems in labour and at delivery as reported to them by the midwives. However, as they moved into the hospital for their second three months, the demands on them would increase greatly.

During his three months as senior house surgeon, Grant took responsibility for 124 cases, and witnessed four deliveries, three by Nicholson and one by Ballantyne. Two of the three cases with Nicholson provide some evidence of teaching: they were both deliveries by podalic version, and precede the three deliveries by version Grant carried out. Whilst the majority of the cases Grant attended continued to be apparently normal vertex deliveries, in contrast to earlier years he was recorded as having responsibility for a number of sick patients, including five with eclampsia, one of whom was delivered by version after death, and two with placenta praevia.

Hunter's Indoor experience was similar, but more extreme. He took responsibility for 153 cases in his second three months, but witnessed none. Despite this, he carried out

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[129] 1912 OCB, case 21 (Dr Ballantyne's quarter) [JWB] [422/21/bal/1912o].
[130] 1912 OCB, case 97 JWB [499/97/bal/1912o].

a variety of deliveries, many of which would, in earlier years, have been the prerogative of the senior doctors (Table 5.16).

Table 5.16
Numbers and Types of Delivery Carried Out Indoors at the ERMH by Dr Hunter, October-December 1912

Normal	Forceps	Version	Craniotomy	Abdominal Delivery	Accouchement Forcé
106	17	4	2	1	1

Source: ERMH Indoor casebooks, 1912

Further, he was responsible for the care of 10 sick patients, four with eclampsia, three with cardiac problems, and three with placenta praevia. In addition, apparently unsupported by his seniors, he had to solve the conundrum of Mrs X, described in the casebook as 'Case of Decapitation outside - Head delivered in Hospital'.[131] Hunter also had his own junior to support, and in October and November he attended with Elliott four difficult deliveries in the Dispensaries.

The experience of these two house surgeons in their senior months illustrate the greater demands made of the post by the hospital and the changes in obstetrics. House surgeons were now expected to have a much wider range of technical skills and medical insight, and apparently to act without supervision. Although the 1911 Regulations for House Surgeons forbade them to 'perform any important obstetrical operation except under the instruction of the Medical Officer', the casebooks furnish only one clear example of advice being given, when 'Sir Halliday Croom was rung up & came to see the patient & decided that all operative treatment to save the child was quite out of the question'.[132] They were given increasing responsibility throughout their six-month stay. Presumably it was in recognition of this that the hospital decided to pay the senior house surgeon 1gn. a week. By 1912 house surgeons at the ERMH were very definitely junior doctors, members of staff, rather than senior students.

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[131] 1912 ICB, case 54 JHC [522/054/hc/1912i].
[132] Edinburgh Royal Maternity and Simpson Memorial Hospital, 'Regulations for House Surgeons, sanctioned by the Directors on 22nd March, 1911', Rule 8; 1912 SOCB, p. 202.

5.6.3 Nurses

In 1912 the names of 80 midwifery pupils appear in the casebooks of the ERMH. Of these, 69 started their training in 1912, and this group have been examined in detail. Figure 5.18 shows the appearance of nurses by week, arranged in order of their entry to training. It will be seen that the first 11 started the previous year. In 1912 the non-medical female pupils were referred to as nurses in the hospital's administrative papers, and this is the title used here, although a number went on to take the CMB examinations. The hospital had been a CMB-approved training centre since 1903. In contrast to the earlier years studied, nurses now joined the hospital in monthly sets, ranging in size from three to ten. No new set started in December 1912: in 1911 this set had consisted of one nurse only. The variation in size of the sets can be seen in Figure 5.19.

Within each set some nurses trained for four months, and some for six. The Register of Nurses recorded that 37 (53%) were taken on for the shorter training, and 32 (47%) for the longer, but did not indicate the individuals involved.[133] In 1909 the Directors revised the Schedule for Nurses, and stipulated six months' training for those without experience, and four months for previously-trained nurses intending to take the CMB examination.[134] Using Figure 5.18, the likely stays of nurses can be calculated until August 1912. This shows 53% staying for four months, 44% for six, and one, Catherine Mackenzie, who was registered as starting in May, but appeared only to carry out deliveries in late August and September.[135] All bar one of the four-month group were trained. In the six-month group 15 of the 20 nurses had had no previous training.

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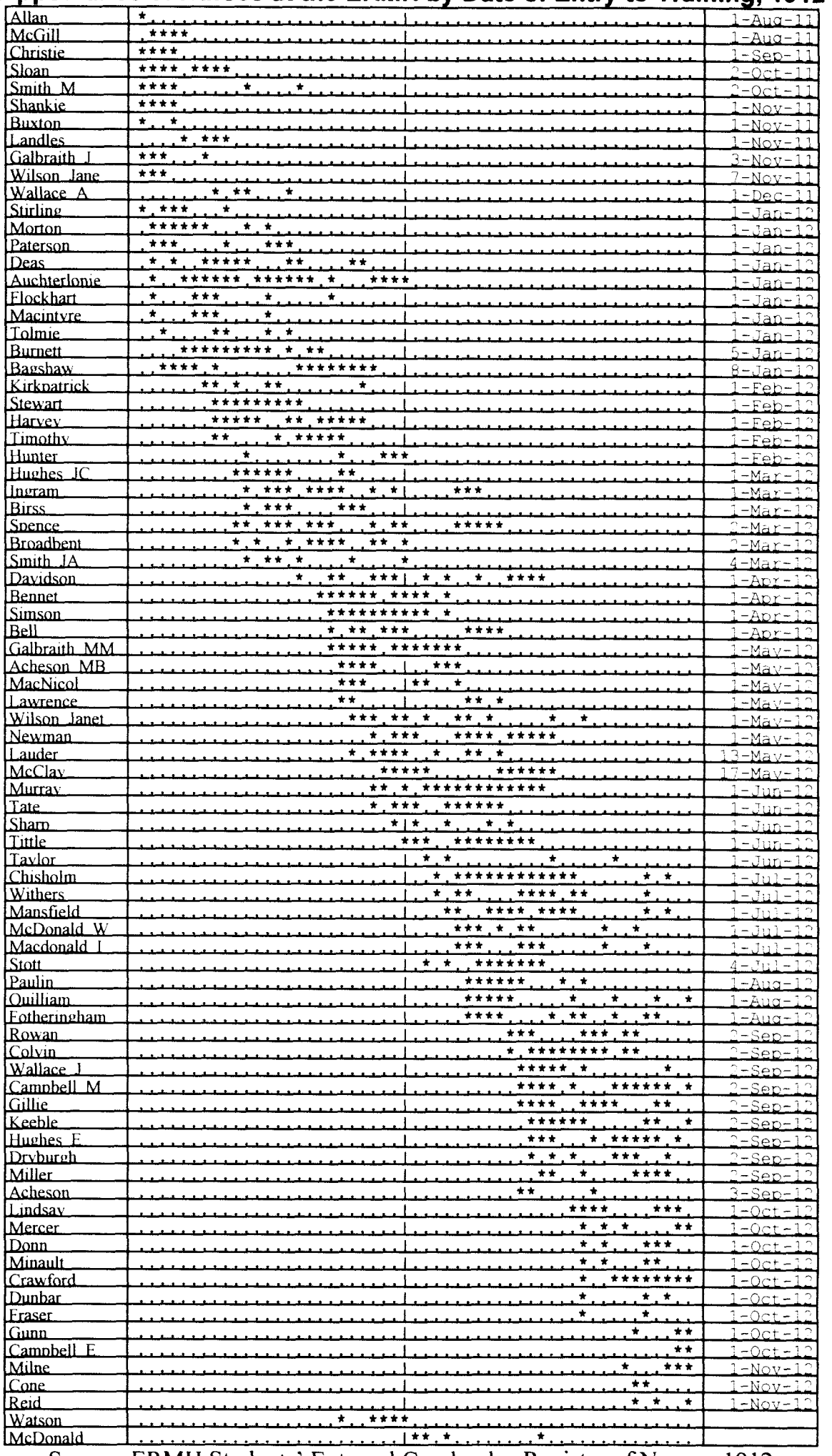
[133] ERMH Register of Nurses, 1892-1928, 1912 classes.

[134] DMERMH, 17 March 1909. At the time, the CMB required 3 months' midwifery training for previously-trained nurses: the significance of the extra month is unclear, but may have added to the reputation of ERMH nurses. (CMB information from Maxine Rhodes, Municipal Maternity Services: Policy and Provision 1900-1939 with Particular Reference to Kingston-upon-Hull and its Municipal Maternity Home (Hull University Ph.D. Thesis, 1996), pp. 122-3).

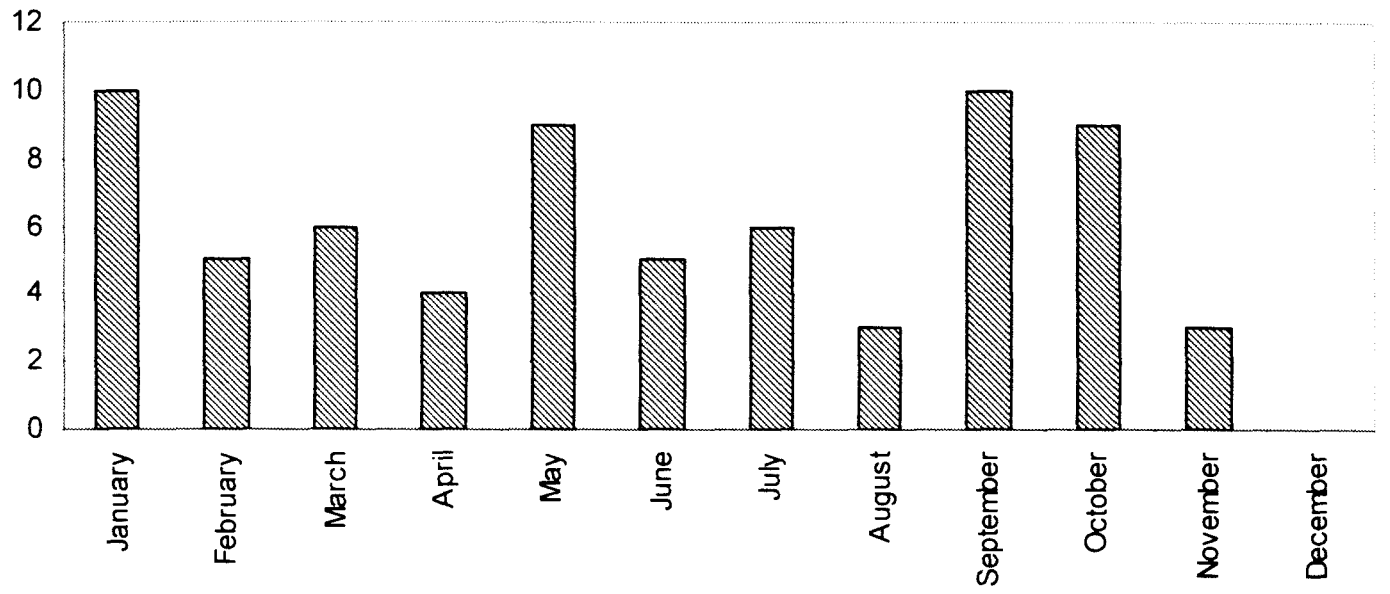
[135] 45 nurses started training between January and August 1912, 20 for six months, and 24 for four. If Nurse Mackenzie stayed for six months, the percentage of six-month trainees in the group would rise to 47%.

Figure 5.18
Appearance of Nurses at the ERMH by Date of Entry to Training, 1912



Source: ERMH Students' External Casebooks, Register of Nurses, 1912
The central line represents the mid-point of the year
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

Figure 5.19 Variations in the Size of classes of Nurses at the ERMH, 1912



Source: ERMH Students' External Casebooks, 1912

Overall, 46% of ERMH nurses had had no previous training, whilst 54% had some nursing experience, ranging from the three years fever nursing and 12 years of district nursing recorded for Isabella Colvin, to the eight months at La Source Nursing School, Switzerland, cited by Blanche Minault. Although this information is not available for the previous years studied, the impression is that by 1912, the ERMH was attracting a different type of pupil with previous hospital experience, and adjusting its training accordingly.

Academic Training

The academic content of the nurses' training was now defined by the requirements of the Central Midwives' Board. After 1905, certificated midwives were required to have knowledge of elementary pelvic anatomy, pregnancy and its complications, including miscarriage and abortion, the symptoms, mechanism, management and course of natural labour, including examination of the pregnant abdomen, and the signs of abnormal labour. They also had to know the varieties of haemorrhage, and appropriate treatment, and the management of obstetric emergencies until the arrival of the doctor, including all necessary drugs. In addition, they had to know the management of lying-in women, including care of the breasts, the use of thermometer and catheter, and the various puerperal fevers. Midwives had also to know the management of infants, whether term or premature, the signs of early

disease in babies, and about breast and artificial feeding. They had to understand the use of antiseptics, the principles of hygiene in the home and in food preparation, and of disinfection of their person, clothes and appliances. Finally, midwives had to know the care of an apparently lifeless child, the laws on burial of a stillbirth, birth registration, and vaccination, and the duties of a midwife defined by legislation.[136] Although technically this syllabus applied only in England and Wales, the ERMH, as a CMB-recognised training centre, (although its pupils were examined south of the border), must have adhered to it. The revised Schedule (see above) refers to 'a Course of Lectures and Practical Instruction given by one of the Physicians to the Hospital',[137] and there is additional evidence that this syllabus was followed in Edinburgh, in the form of lecture notes taken by a pupil midwife at the Edinburgh Lying-in Institution in 1910.[138] The ERMH casebook data provide little evidence of academic training as such, although its effectiveness can be seen in the regular and careful charting of maternal temperature, the investigation of ill-health, and the readiness to call for medical aid when it was considered necessary.

Practical Training

However, as in the earlier years studied, the casebooks do provide evidence of the practical training received by the nurses. Practical training in midwifery had gained in importance in the last quarter of the nineteenth century, and midwives hoping to take the examination of the London Obstetrical Society had to have attended 20 labours under supervision, as well as having good theoretical knowledge.[139] At the ERMH the debate over the relative value of witnessed cases and 'hands-on' deliveries evidently lingered. CMB applicants were also expected to have had 20 cases of 'personal delivery' in training. In January 1907 Nurses Wright, Macmillan and Hoddinott complained of insufficient personal deliveries to the Directors, who immediately queried the accuracy with which the physicians were completing the

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[136] Stanley B. Atkinson *The Office of Midwife (in England and Wales) under the Midwives Act, 1902* (London: Baillière, Tindall and Cox, 1907), pp. 62-3.
[137] DMERMH, 17 March 1909.
[138] Notebooks of Jessie Inglis Cuthbert, Edinburgh University Library, [LHSA, MAC GD1/13/1-2].
[139] Brooke Victoria Heagerty, Class, Gender and Professionalization: the Struggle for British Midwifery 1900-36 (Michigan State University, Ph.D. Thesis, 1990), p. 5.

Figure 5.20
Appearance of Nurses at the Leith Branch, by Week and Date of Entry to Training, 1912

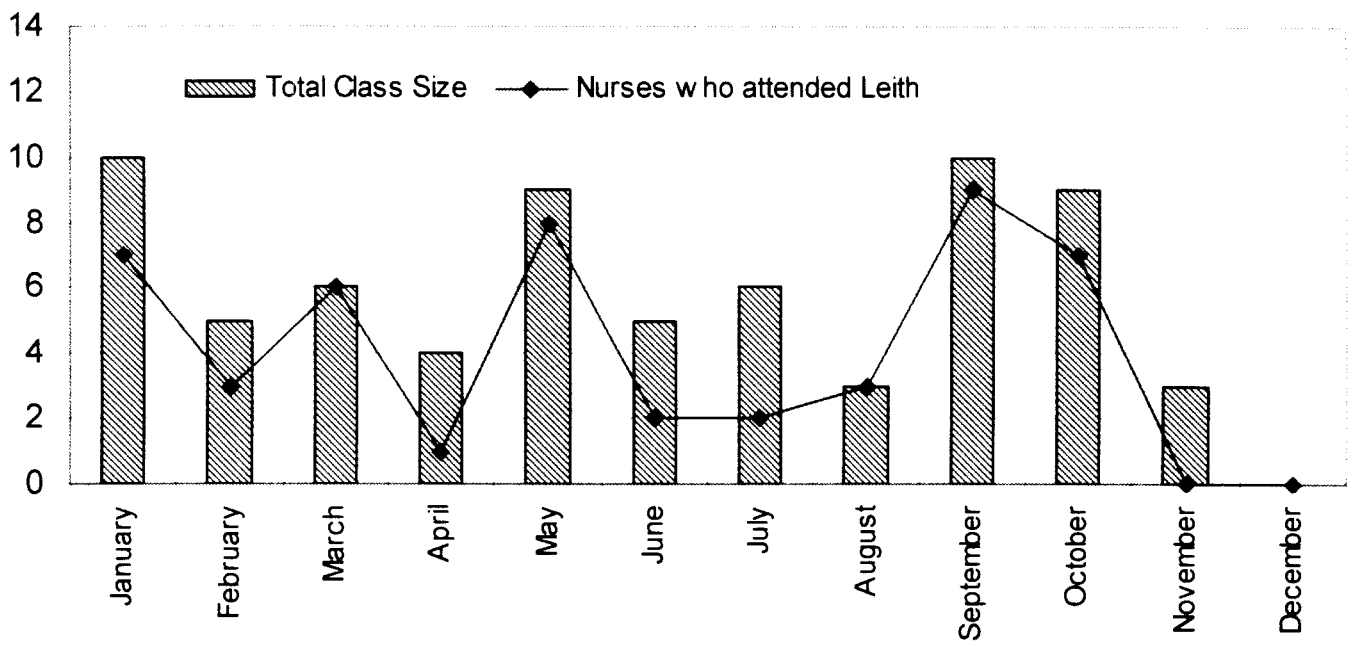
Wallace_A	******.....|.....	01-Dec-11
Landles	*****.....|.....	01-Nov-11
Buxton	****.....|.....	01-Nov-11
Tolmie	...*****.....*.....|.....	01-Jan-12
Paterson	....*****.....|.....	01-Jan-12
Stirling	.....***.....|.....	01-Jan-12
Morton	.....***.....|.....	01-Jan-12
Flockhart	.....****.....|.....	01-Jan-12
Macintyre	.....****.....|.....	01-Jan-12
Deas	.....**.....|.....	01-Jan-12
Hunter	.....****.....|***.*.....	01-Feb-12
Harvey	.....***.....|.....	01-Feb-12
Birss	.....*****.....|.....	01-Mar-12
Kirkpatrick	.....****.....|.....	01-Feb-12
Hughes_JC	.....*****.....|.....	01-Mar-12
Smith_JA	.....***.....|.....	04-Mar-12
Broadbent	.....****..|.....	02-Mar-12
Ingram	.....****..|.....	01-Mar-12
Spence	.....***..|.....	02-Mar-12
Acheson_MB	.....******.....	01-May-12
Lawrence	.....****.....	01-May-12
MacNicol	.....****.....	01-May-12
Davidson	.....|**.....	01-Apr-12
Lauder	.....|**.....	13-May-12
McClay	.....|..*****.....	17-May-12
Newman	.....|..**.....	01-May-12
Wilson_Janet	.....|..**.....	01-May-12
Sharp	.....|...****.....	01-Jun-12
Taylor	.....|...****.....	01-Jun-12
Macdonald_I	.....|.....****.....	01-Jul-12
Withers	.....|.....****.....	01-Jul-12
MacKenzie_C	.....|.....**.*.....	01-May-12
Fotheringham	.....|.....***.....	01-Aug-12
Quilliam	.....|.....***.....	01-Aug-12
Acheson	.....|.....****.....	03-Sep-12
Paulin	.....|.....***.....	01-Aug-12
Rowan	.....|.....*...*.....	02-Sep-12
Gillie	.....|.....***.....	02-Sep-12
Hughes_E	.....|.....***.....	02-Sep-12
Campbell	.....|.....***.....	02-Sep-12
Dryburgh	.....|.....***.....	02-Sep-12
Miller	.....|.....***.....	02-Sep-12
Keeble	.....|.....***.....	02-Sep-12
Lindsay	.....|.....***.....	01-Oct-12
Wallace_J	.....|.....****...	02-Sep-12
Gunn	.....|.....***..	01-Oct-12
Mercer	.....|.....***..	01-Oct-12
Minault	.....|.....***	01-Oct-12
Donn	.....|.....**	01-Oct-12
Dunbar	.....|.....**	01-Oct-12
Royal Maternity Nurses Simpson Memorial	.....*.....*....*.*....*.....*.*...*.....	

Source: ERMH Students' External Casebook (Leith Branch), Register of Nurses, 1912
The central line represents the mid-point of the year
Each '.' or '*' indicates a week.
'*' indicates at least one appearance by the named person during the week.
'.' Indicates no appearance during the week.

CMB schedules, implying that witnessed cases were being counted as personal deliveries. They also acceded to Matron's request to open an additional branch in Leith, specifically to provide extra cases.[140] Most of the nurses who started training in 1912 attended the Leith Branch in addition to the main dispensary, typically in groups of three or four at any one time. They stayed for between two and five weeks. Their appearance by the week can be seen in Figure 5.20.

In sending pupils to Leith, no differentiation was made between four- and six-month trainees, and nurses went from every set (Figure 5.21). In total, 48 (69%) attended in the year.

Figure 5.21
Numbers of Nurses from Each Class who Attended the Leith Branch in 1912



Source: ERMH Students' External Casebook (Leith Branch), Register of Nurses, 1912

Once based in Leith, the nurses' work was supervised by a midwifery sister, Sister Dewar, indicating the independence of the Leith Branch. In contrast, main dispensary work was supervised by the hospital nursing staff and the house surgeons.

The revised Schedule stated 'Nurses are on duty in rotation in the Labour Ward, under the supervision of the Doctor and Charge-nurse', stressing Indoor rather than

[140] DMERMH, 21 January 1907.

Outdoor practical experience, although this is not recorded in the casebooks.[141] However, in 1912 the nurses delivered 1,178 women through the dispensary and the Leith Branch. On average they delivered 17 cases each, although the lowest number recorded by an individual was 12, and the highest 26. In addition, they witnessed deliveries, usually by their colleagues, each nurse attending on average six, and giving an average of 23 delivery experiences each. Nurses also worked Indoors in the hospital. The periods in which individuals did so can be extrapolated from the gaps in their appearances in Figure 5.18. They were not recorded attending any Indoor patients. Although the absence of Indoor cases means the record is incomplete, the nurses almost certainly did achieve the 20 cases necessary to take the CMB examination.

The nature of the cases the nurses attended, and especially their management of any problems, indicates that their role was now confined to the normal as taught, and that any deviation from the norm must be reported to higher authority. At Leith the nurses attended 491 cases, of which the great majority (391) delivered without incident. However, on eight occasions the nurses had to deal with antenatal problems, including a patient with a transverse lie, who was transferred to the ERMH. On four of these occasions, including the above, Sister Dewar also attended the case. Pupil nurses also recorded problems in labour in 58 cases, of which 31 merited a visit by Sister, and the house surgeon also attended in 20 of these. Sister Dewar was also present at five of the eight breech deliveries, and three of the five twin deliveries recorded. In the absence of other problems these were still considered to be normal deliveries and within the midwife's remit, but Sister's presence implies either increased concern or a teaching opportunity. The pupils showed the effects of their teaching most in their management of the third stage: in 49 cases a problem was recorded, most commonly ragged membranes. In 22 cases Sister was summoned, but in only six of these the house surgeon was called, usually to deliver the placenta.

Sister Dewar played a pivotal role in the Leith Branch. Overall she attended 87 cases, typically because of some problem. However, she also provided some practical

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[141] DMERMH, 17 March 1909.

teaching, witnessing 16 different pupils deliver apparently normal cases. In the case of Nurse Paulin, who had had no previous nursing experience before she came to the ERMH, Sister witnessed four of her nine deliveries, although she had delivered eight cases prior to being sent to Leith. Whilst the casebook data from Leith suggest that pupil midwives were responsible for all normal deliveries, in difficulties they appealed first to Sister Dewar for advice. Possibly because of distance from the parent hospital, she acted as a filter on such cases. Only when she felt medical assistance might be needed, was the house surgeon called, although she could also act independently: Mrs A was '... sent in [to the hospital] by Sister Dewar (of Leith Branch R.M.H.) ... [having had] 4 fits after delivery'.[142]

The experience of nurses in the main dispensary was similar, and they delivered unsupervised 535 normal vertex cases, four breech presentations, and four sets of twins. Unlike Leith, there is no obvious chain of authority evident in the casebooks. In 1908 the Medical Board informed the Directors that 'at present the Nurses report directly to the Matron and this places a very heavy responsibility upon her .... [She] deserves praise for the way in which she has carried out this duty as the healthy state of the Outdoor record abundantly proves'.[143] They felt that nurses should report problems to the house surgeon in future, but there is only a little evidence of this happening. In one case, the patient 'noticed that cord was hanging down about 5pm so summoned a nurse from RMH who called Dr Ritchie to see case as she c[oul]d make nothing of the presentation. ... [he] diagnosed a transverse presentn. and sent case in to RMH'.[144] As in Leith, most problems were associated with the third stage of labour. Difficulties with the membranes or placenta were recorded in 58 cases: the house surgeon was called in 22 of these. He was thus called more frequently than in Leith. Nurses were also present when nine of their patients were delivered by the house surgeon, but this was treatment rather than demonstration.

The experience of the nurses in 1912, as revealed in the casebooks, suggests that even if they were students, they were a necessary part of the hospital staff, and that

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[142] 1912 SOCB, pp. 45-6.
[143] DMERMH, 22 October, 1908.

they applied to their practice the lessons on the medical care of women in childbirth they were currently learning. Midwifery was now emphasised as the management of normal delivery, and anxieties about failure to notify problems, or to call medical aid, led to regular recording of problems that ultimately required no treatment. However, in contrast especially to 1870, the casebooks suggest there was less practical teaching at delivery: whilst the nurses did witness 467 cases, approximately a third of those they delivered, in the great majority they witnessed their contemporaries in action, rather than medical staff.

The use that students made of their training was varied. Despite the hospital's accreditation as an approved training centre for midwives, there are few signs that enrolment as a certificated midwife in England and Wales was the aim of most of its pupils. Only 20 nurses were recorded as taking the Central Midwives Board [CMB] examinations, including 17, slightly less than half, of the 38 trained nurses. However, the group who did take the examination had certain defining features. Most (85%) were previously trained, and of these all except one appear to have taken the shorter training, the exception being Jessie Burnett from Glasgow Royal Infirmary. One of the three who took the examination without previous nursing experience took the six-month training: the other two started too late in the year for this to be charted, although it can be assumed that they did train for six months. Three of the group gave English addresses, two Irish, whilst the rest were Scots. Their average age was 31, although the oldest was 44, and the youngest 25. All were single.

The CMB group can be compared with those who in 1915 enrolled with the CMBS by virtue of their hospital certificate. There were 15 in this group, 10 of whom had no previous training when they attended the ERMH. Fourteen were Scots, the exception being Greta Cone, of Sleights, Yorkshire. The length of stay is known for eight nurses, and of these, five, all without training, stayed for six months. The three who stayed only four months were trained, including Evelyn Simson, who gave the Hospice as her previous experience. In this group too the average age was 31,

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[144] 1912 SOCB, pp. 57-9.

ranging from 46 to 27. Again, all were single. One can suggest that the CMB group largely comprised trained nurses looking for further qualifications to add to their portfolio, or, in the case of Scots, a wider area in which to work, whereas those who enrolled in 1915 had one skill, but intended to continue in a profession in which they were already established.

Both groups can be compared with the majority who neither took the CMB examination, nor enrolled in 1915. Again, most were Scots, although 5 came from England, and one from Switzerland. Again, the average age was 31, although the range was from 20 to 39. The only two recorded married women were in this group. None of the group whose full stay can be identified, appeared to leave early, with the possible exception of Catherine Mackenzie. Almost half of the group (46%) was trained. Presumably they found they disliked midwifery and returned to other fields of nursing. They had access to other means of nursing employment, and thus were less dependent on acquiring recognised qualifications in midwifery. Alternatively, they may have planned to work only as ladies' nurses, under supervision, using their hospital certificate only in support of this. However, slightly more than half had had no relevant previous experience, but having invested six months on a training course appear to have turned their backs on it, or followed the ladies' nursing route. One could argue that the Scots did not feel the need to enrol, but by 1915-6 had found other employment, possibly associated with the war. However, this would not apply to Englishwomen involved.

By 1912 the experiences of the hospital staff were very different, and reflect the changes that were occurring in obstetrics and medical and midwifery education. Senior doctors were now becoming more involved in hospital care as well as in medical education. In terms of the ERMH, their practice was confined to the most unusual and the most technically difficult cases. House surgeons were now definitely considered junior staff. Their longer stay and pay in the second three months indicates that the hospital recognised and rewarded the superior technical skills they were now required to learn. The expectations of both grades of doctor indicate changes in obstetrics and midwifery: that the field had become more routinely

technical and standardised. However, the nurses had undergone most change. Socially, they were on average two years younger than in the previous study years, and single, and therefore presumably looking for a full-time profession. Almost half the attending nurses were previously-trained, in contrast to the previous years studied, and this, and the content of the course with its emphasis on the need for medical aid for the possibly abnormal, encouraged medicalisation of childbirth. The midwife still had a great deal of independence, but, ultimately, she was a filter for the doctor.

5.7 Conclusion

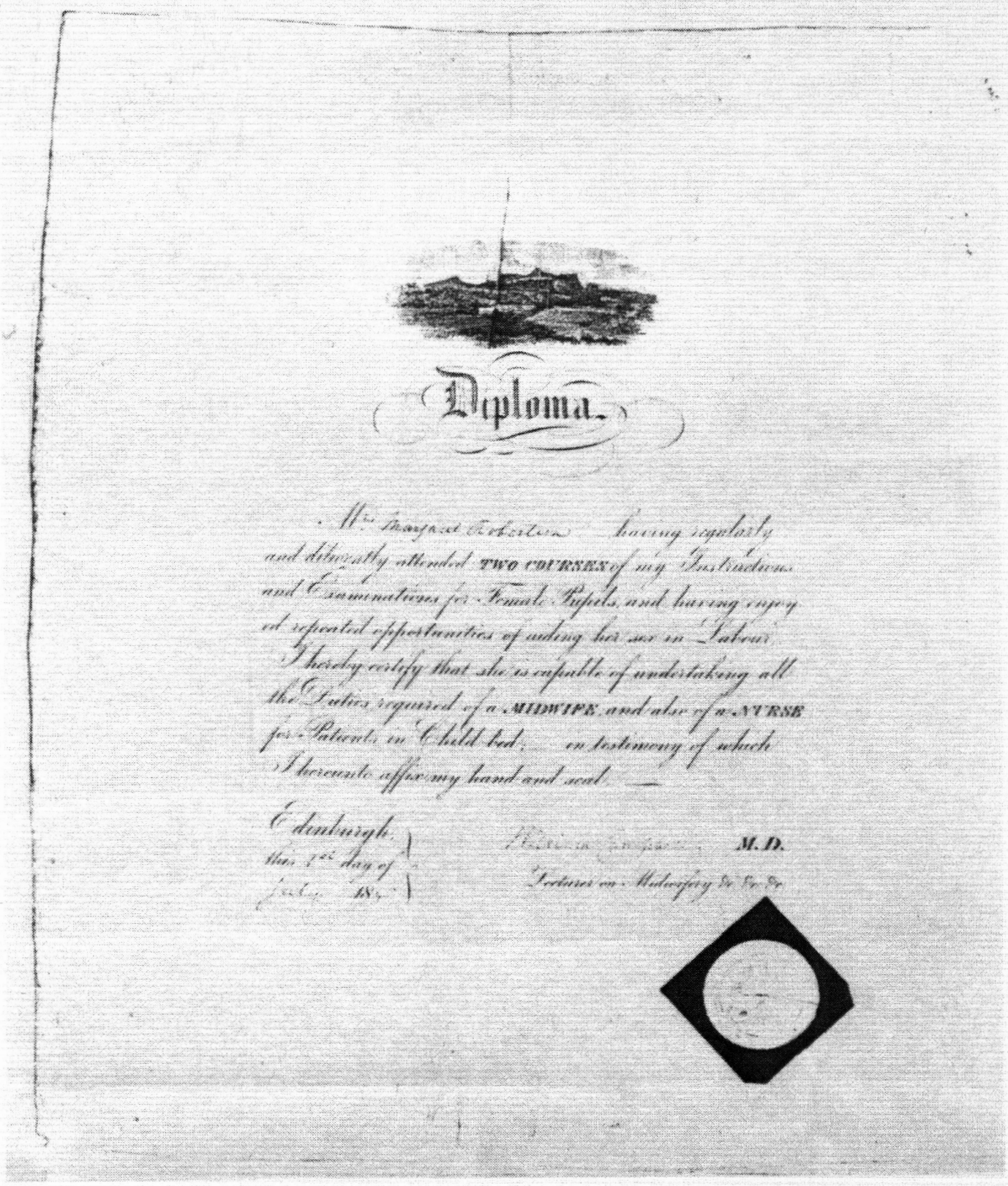
This chapter has examined the changing education and experience of ERMH staff in the period 1850-1912, based principally on detailed analysis of casebook data. It has demonstrated changes in the management and understanding of childbirth, and also in the social and medical status of midwifery. The changes follow three main themes. The first is the organisation of the hospital itself. Over the period it moved from a minor charity to a well-respected maternity hospital, and this is illustrated firstly by the changes in the appearance pattern of the senior doctors, and by the relationship between it and their careers. In the 1860s, although it is not apparent from the casebooks, doctors seriously suggested the hospital's closure, and their involvement was a charitable commitment: by 1912 it was professionally desirable to be associated with it. However, the data also suggest some antagonism between the doctors and directors. As they grew in confidence, the doctors appear regularly to have ignored the directors' restrictions on their practice, particularly with regard to the house surgeons. Changes in the hospital are illustrated in the second place by the alteration in the organisation of the midwives over the period. They changed from being very short-term attendants with no caring role in the hospital, to the principal providers of care both Indoors, and, particularly, Outdoors, whilst still training.

The second theme is that of changes in midwifery and obstetrics. At the beginning of the period, the level of skill and knowledge among the three junior groups at the hospital was similar, but by 1890 differentiation was occurring. The house surgeon was no longer a superior student, but was required to have much greater medical

knowledge and technical skill than the midwives or medical students. A select few were able to use the obstetric experience obtained to make a career, although the majority became GPs, in which they differed little from the students. By 1912 increasing differentiation had led to stratification of the caring groups, at least in the dispensaries: midwives now cared for the normal cases, and acted as a screen so that only problem cases reached the doctor. The changing expectations of the nurses also indicate the increasing medicalisation of childbirth itself. At the beginning of the period, it was expected that nurturing care at delivery would be provided or supervised by family and friends, or, in the hospital, by fellow patients. By the end of the period studied, such care was provided by nurses according to the strict formula they had been taught.

The final theme is that of changes in education. The casebooks provide particularly good evidence of the changes in practical education of medical students. In 1850 the emphasis was apparently on copious experience, with little teaching, but by 1890 the number of individual medical student cases had declined in favour of teaching in cliniques. In a striking inversion, by 1912 the emphasis for midwives was on experience, rather than theoretical lectures. Increased dependence on the doctor was encouraged.

Detailed examination of all the ERMH casebook data from a given year is often illustrative rather than giving rise to new theories. However, one exception to this is the apparent emphasis on midwifery training in 1870. Detailed exploration of the education and experience of the professional staff has shown major changes in midwifery and obstetrics in the 62 years surveyed. In that time, midwifery developed into a respected academic subject, increasingly defined and analysed, and its treatments became more pro-active. Childbirth itself can be demonstrated to have moved within the medical gaze, and the roles of its attendant professionals to have become more stratified and defined.



Diploma

Mrs Margaret Robertson having regularly and diligently attended TWO COURSES of my Institutes and Examinations for Female Pupils, and having enjoyed repeated opportunities of aiding her use in Labour

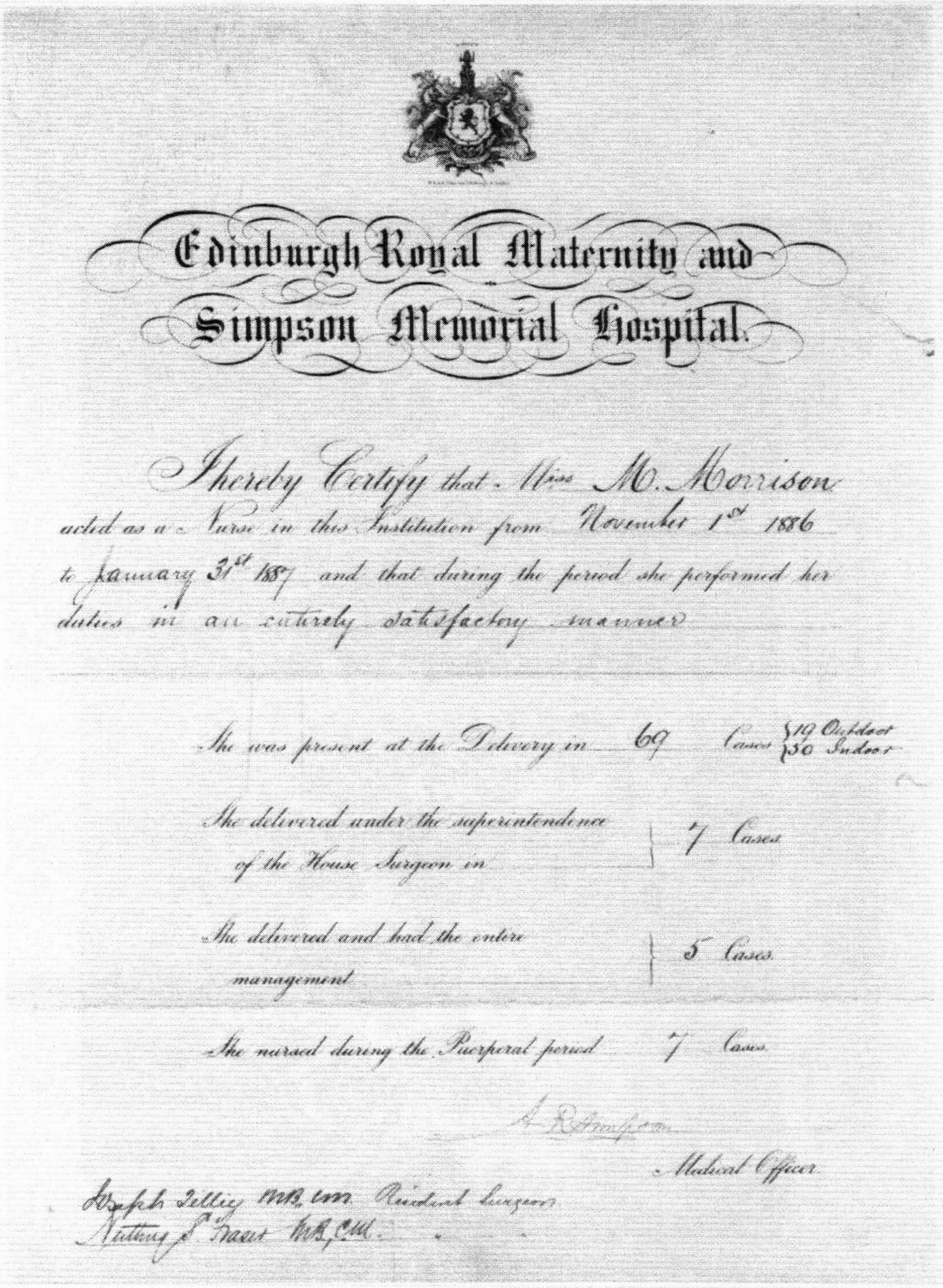
I hereby certify that she is capable of undertaking all the Duties required of a MIDWIFE, and also of a NURSE for Patients in Child bed. — in testimony of which I hereunto affix my hand and seal. —

Edinburgh, this 1st day of [illegible] 18[illegible]

[illegible] M.D.
Lecturer on Midwifery &c &c &c

Illustration 5.1

Lecture Certificate of Mrs Margaret Robertson



Edinburgh Royal Maternity and
Simpson Memorial Hospital.

I hereby Certify that Miss M. Morrison
acted as a Nurse in this Institution from November 1st 1886
to January 31st 1887 and that during the period she performed her
duties in an entirely Satisfactory manner

She was present at the Delivery in 69 Cases { 19 Outdoor / 50 Indoor

She delivered under the superintendence of the House Surgeon in 7 Cases

She delivered and had the entire management 5 Cases

She nursed during the Puerperal period 7 Cases

A Simpson
Medical Officer

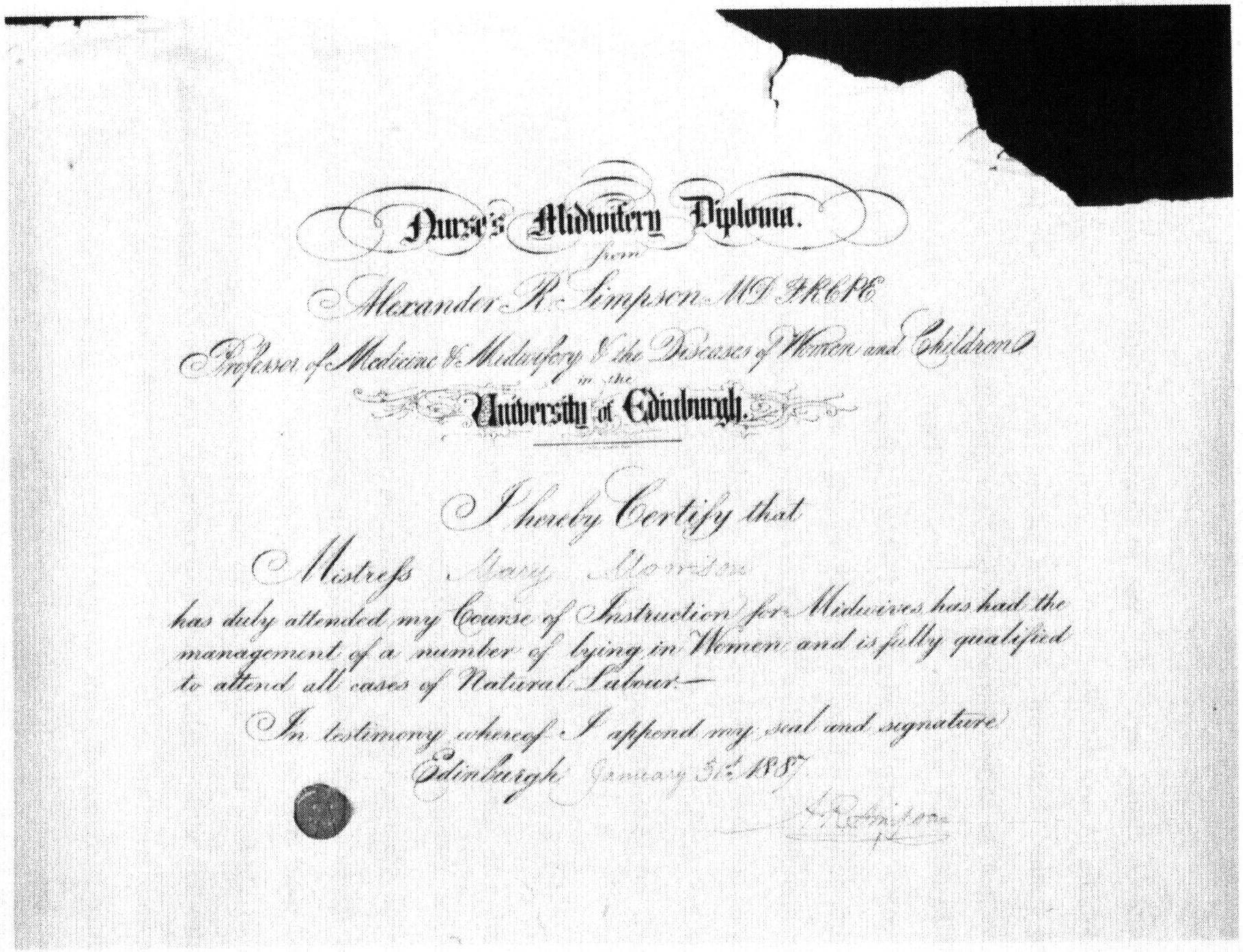
Joseph Tilley MB CM Resident Surgeon
Matthew J. Fraser MB, CM

Illustration 5.2

Hospital Certificate of Miss Mary Morrison

Illustration 5.3

Edinburgh Royal Maternity and Simpson Memorial Hospital Staff



Nurse's Midwifery Diploma.

from

Alexander R. Simpson M.D. F.R.C.P.E.

Professor of Medicine & Midwifery & the Diseases of Women and Children

in the

University of Edinburgh.

I hereby Certify that

Mistress Mary Morrison

has duly attended my Course of Instruction for Midwives has had the management of a number of lying in Women and is fully qualified to attend all cases of Natural Labour—

In testimony whereof I append my seal and signature

Edinburgh January 5th 1887

A. R. Simpson

Illustration 5.4

Lecture Certificate of Miss Mary Morrison

Chapter 6

Conclusions

This thesis has examined the development of the Edinburgh Royal Maternity Hospital and its associated Outdoor provision, and the medicalisation of childbirth among the poor of the city, during the second half of the nineteenth century and before the First World War. Following the lead of recent histories of maternity hospitals outwith Britain, it has sought to analyse the changing function of the hospital, arguing that, over the period 1844-1914, medical concerns came to predominate at birth. This thesis is not a general study of childbirth in Edinburgh at the time, as, in the period studied, most births were dealt with by a family-engaged midwife, doctor, or even a family member. However, the ERMH was the largest charitable provider of maternity care in Edinburgh, and, as a significant training hospital for midwives and medical students, it had a major influence on future practice.

The thesis is based principally on detailed examination of whole-year data drawn from Indoor (hospital in-patients) and Outdoor (dispensary out-patients) delivery casebooks and births registers for four discrete years, at approximately 20-year intervals. These data have been studied in association with other hospital and university administration records. Although maternity hospital records have been used before by historians, with the exception of Janet McCalman's study of the Royal Women's Hospital, Melbourne, there has been little analysis of the contents of such routine casebooks, where they still survive.[1] However, as has been shown in this thesis, such records provide a rich source of material about the nature of patients attending the hospital, the treatment they received, and the staff who attended them. In particular, the interaction between the numerical analysis of the delivery

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[1]Janet McCalman *Sex and Suffering – Women's Health and a Women's Hospital: the Royal Women's Hospital, Melbourne 1856-1996* (Melbourne: Melbourne University Press, 1998).

casebooks and births registers, and additional, specific case or personal material from other records, adds depth and detail.

Casebook analysis has enabled patients at the ERMH to be seen simultaneously in relation to their family background and their medical treatment, and thus as both social and medical entities. Both Indoor and Outdoor patients can be contrasted with the general childbearing population with regard to age and parity. Use of whole-year data places unusual cases, which dominate medical journals and other sources, within the daily practice of the hospital, thus allowing care to be seen in a contemporary context. In addition, the casebooks provide a record of the individual hospital experiences of named staff members. Thus, use of these casebooks, whose detail permit seeing individual births in both a medical and social context, and the placing of such births in a wider statistical picture, provides an exceptionally detailed picture of birth among the poor in Edinburgh in the later nineteenth century. However, this is not to suggest that casebooks have proved an ideal source. The use of material intended only for the era in which it was written, can lead to problems of interpretation, and these have been noted in the thesis. For example, it can only be deduced from contemporary writings and references to practices within the hospital, that the purpose of increasing the attendant nurses Outdoors was the introduction of antiseptic methods. It is not explained in the casebooks.

This thesis has explored in detail three main aspects arising from the data collected: the patients who used the ERMH, both Indoor and Outdoor; the treatment they received; and the medical and midwifery staff who attended them. With regard to Indoor patients, it has concluded that until the early twentieth century they were not typical of the childbearing population in age or parity, nor of the city population in terms of origin, occupation or marital status. The great majority used the hospital primarily as a social shelter. However, by 1912, there had been a major change in the attitude to childbirth among both Indoor and Outdoor patients. There was widespread acceptance of a strict regime of care by medical professionals and their pupils, and an increase in the use of the medical facilities of the hospital by married but sick parturients. The casebooks hint that this was the result of a decline in family or

neighbourhood support, whilst the hospital's Annual Reports suggest that increased use of its services was the result of a positive decision by patients. The increased use of 'Mother and Baby' homes to provide shelter for single mothers, particularly once the arrangement was acknowledged in 1907, further indicates the change in the hospital's role from social to medical. This thesis has shown that patients were not passive, but by their refusal or acceptance played an important role in shaping the institution or services they used. Thus, the increased use of dispensaries, and, ultimately, the move to in-patient care in Edinburgh, resulted as much from patient choice as from institutional imposition. However, the thesis also suggests that hospital-based material is ultimately a poor source for patient motivation. Particularly in the field of maternity care, there is a need for a patient-centred study of motivation towards particular types of care, encompassing both urban and rural settings, and different social classes.

This thesis has also examined the treatment offered to both Indoor and Outdoor patients over the 70 years of the study. With regard to the great majority of patients who delivered without any recorded problems, it has concluded that, by 1912, their birth experience was dominated by medical requirements, primarily as a result of medical recognition that the risk of puerperal infection could be reduced by strict management. These patients' labours were supervised by the pupil midwife in attendance, and it was assumed that they would accept intervention at delivery, including hospital admission, should it prove necessary. Attendants had also become more pro-active. As has been shown, minor third stage problems were now investigated before they gave rise to infection: this is particularly noticeable in the increase in recording of instances of ragged placentae. Unwillingness by patients to accept advised treatment was commented on. The puerperium was also supervised, by means of daily nursing visits: patients were monitored for signs of infection, and medication was given almost routinely. Bedrest was strongly encouraged, if not enforced. However, despite this evidence of medicalisation, birth itself was still regarded as a physiological process, for which pain relief was seldom necessary.

The ERMH casebooks and associated material suggest that by the last quarter of the nineteenth century, maternity professionals had become more dictatorial, particularly with regard to maternal position at delivery and the necessity of bedrest afterwards, possibly using anxiety about infection as a rationale. However, as has been noted, there is much less hospital material on normal childbirth: the normal was of less interest to a medical institution. Therefore there is a need for further study to locate the development of the hospital's management of labour, delivery and the puerperium within both earlier and non-medical practice at birth, and within the concurrent gynaecological experiences and practice of its senior doctors.

The changing management of abnormal labour has also been analysed, particularly the increasing use of instrumental intervention. The lack of synchronicity with the introduction of anaesthesia has been noted. Between the years 1870 and 1890, intervention at delivery ceased to be a rare event in the hospital or dispensary that necessitated the presence and skill of a quorum of senior doctors, and almost always indicated obstructed labour. It became much more common, and much more successful in terms of the survival of both mother and infant. However, any change in practice in 1890 did not result from a large increase in patients attending the ERMH knowing in advance that they needed specialist obstetric help, nor from such patients being sent for admission by outside doctors, although by 1912 this was more common. Nonetheless, in the second two years of this study, a marked increase in instrumental deliveries was recorded, and abdominal surgery was introduced. Further, in 1890 such an increase occurred in both Indoor and Outdoor cases, indicating a change in medical practice without a corresponding change in patients' attitudes towards the hospital. However, by 1912 the proportion of intervention cases in the dispensaries had fallen, as by then any patient requiring more than a straightforward forceps delivery was admitted to the hospital. It should be noted that the casebook records suggest that, despite the increased number, none of these interventions was undertaken lightly.

A similar general increase in intervention, and thus in presumed medical confidence, has been noted by Loudon.[2] Both he and Bashford link this new confidence in obstetricians to the introduction of antiseptic treatment, which allowed doctors to claim superiority over midwives.[3] However, this generalisation seems less convincing in a hospital-led setting, where maintenance of high levels of cleanliness and application of antiseptic treatment was one of the functions of the maternity nurses. Whilst ideas of surgical cleanliness from surgical departments were adopted, and the similarity between the placental site after delivery and a surgical wound before closure was acknowledged, senior doctors were also aware that instrumental intervention was a major source of infection in their patients. To associate a change in intervention policy with antisepsis only would require it to have caused a major change in the mental attitude of obstetricians. As a result, they would have to consider themselves no longer physicians but surgeons, employing a surgical technique, and therefore more willing to use instruments, and they would therefore have to have reconstructed birth as a surgical rather than a natural event. In addition they would have to believe that prolonged labour itself was a cause of increased infection, a risk that would actually be diminished by instrumental intervention under antisepsis.

There is some evidence from Edinburgh that such a change in mindset did take place, but that it was associated with more than the introduction of antisepsis, instead being linked with the increased professional status and knowledge of senior doctors at the ERMH. Supplementary data from Medical Directories (discussed in Chapters 2 and 5) indicates that in the final quarter of the nineteenth century, the expansion of the medical schools, with an associated rising demand for lecturers, conferred greater professional status on the senior doctors at the ERMH. Increased demand for their

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[2] Munro Kerr associated this with improved obstetric technology, but the ERMH evidence suggests this was not always effective. (J. M. Munro Kerr, R. W. Johnstone, Miles H. Phillips (eds) *Historical Review of British Obstetrics and Gynaecology* (Edinburgh : E. & S. Livingstone Ltd, 1954), pp. 74-6).
[3] Irvine Loudon *The Tragedy of Childbed Fever*, (Oxford: Oxford University Press, 2000), pp. 134-150; Alison Bashford *Purity and Pollution – Gender, Embodiment and Victorian Medicine* (London: Macmillan Press Ltd, 1998), pp. 63-83. However, Loudon previously ascribed this to a new professional confidence, arising in part from the emergence of gynaecology. (Irvine Loudon *Death in Childbirth: an International Study of Maternal Care and Maternal Mortality 1800-1950* (Oxford: Clarendon Press, 1992), pp. 183-4.

educational services also permitted greater specialisation in obstetrics and gynaecology. Thus, at least at the ERMH, changes in intervention seem rather to be associated with increasingly confident and pro-active doctors, and an increase in acceptance of such treatment by patients, rather than the safety net of antisepsis as such. By 1912 the casebook data suggests that the emergence of senior doctors as confident practitioners, only called for cases demanding a high level of medical, surgical and obstetric skill and knowledge, was complete.

To ascribe an increase in intervention at delivery to increasing professional skill and specialist knowledge calls into question recent historical interpretation of intervention as a direct result of the widespread use of anaesthesia, a distinct lack of respect for female clients, and a shortage of time. However, the circumstances in late nineteenth-century Edinburgh, with its expanding medical schools, a maternity hospital, and a group of local specialists, were most unusual, and unlikely to be matched outside the major conurbations. Thus, the reasons for an increase in intervention in Edinburgh may not be valid elsewhere, and do not necessarily preclude an interpretation based on more abusive treatment, particularly by general practitioners. It can also be suggested that the pupils of senior doctors in Edinburgh acquired their masters' approach to delivery without the skill or experience necessary to be effective. However, the apparent change in mindset implies that there is a need to examine the background, skills and experience that went into creating the early specialists in obstetrics and gynaecology, as well as the treatment they gave.

The training and experience of the juniors, the house surgeons and pupils at the ERMH, have also been examined in Chapter 5. Three general conclusions arise from the chapter. Firstly, over the period studied, the hospital developed from a small charity to a well-respected maternity hospital. This is reflected in the changes in the organisation of the senior doctors and, in particular, of the midwifery nurses, in the competition for places among prospective house surgeons, and in the increased number of medical students. Secondly, practical midwifery education for both male and female pupils was subject to considerable change over the period, reflecting the varying value placed upon 'hands-on' experience, and to some extent, the over-

crowding caused by the expansion of the medical school. Thirdly, over the period studied, a differentiation in level of knowledge and experience occurred between the three junior groups at the hospital. This is apparent in the presumed increased nursing role of the midwifery nurses in 1890, and by 1912 it had led to clear stratification of the caring professionals, in which the midwives cared for normal cases only, replacing, or at least dominating, the care of family and friends.

By 1912, the pupil midwives at the ERMH were employed as the lowest professional group providing care to an increasing number of patients, bringing them within the medical orbit of the hospital. In an astute commercial move, the ERMH had obtained CMB approval for its training regime. The change in the nurses' background reinforces their role in the medicalisation of childbirth, as an increasing number of pupils had had previous experience of the care of the sick under the general direction of a doctor, typically as trained nurses. The increased number of single women attending also indicates a further change in the approach to childbirth. Evidently a much lower value was now placed on the previous personal experience implied by being, or having been married, which in earlier times had been considered so desirable. Care in childbirth was to be in the hands of professionals and carried out according to a formula, not extrapolated from personal experience.

Greater emphasis on practical experience in midwifery training also indicates both that midwives were no longer expected to have had previous experience, and that they were now required to learn approved techniques. When this is contrasted with the apparent decline in practical midwifery experience suffered by Edinburgh medical students, the assumption can be made that this also illustrates a new understanding of the role of midwives as dealing only with the practicalities of birth, whilst doctors brought a more academic approach. The increase in single women, presumably in search of a full-time occupation, also implies an increasingly professional outlook, although this implication is weakened by the few surviving biographies of eighteenth and nineteenth-century midwives which suggest that midwifery was a desirable occupation for women left with a family but without a male provider. In the changes in the midwives at the ERMH can be seen the

development of the dedicated professional women who contributed so much to British midwifery in the twentieth century.

These findings at the ERMH have a number of implications for the history of midwifery. Firstly, although these data precede the establishment of the Central Midwives Board for Scotland, it is evident that by 1912 both Scottish and English pupils were seeking access to permanent employment. Their previous training and comparative youth suggest they intended to acquire professional skills, rather than the means to a part-time role in their own community. This is comparable with changes noted in CMB enrolees south of the border. Secondly, the data imply that the post-registration profession of midwifery was itself based on the introduction of medical imperatives to childbirth, although at a much less complex level of medicalisation than is criticised today. Thirdly, there is minimal evidence of antagonism to midwives (as opposed to GPs) in the ERMH data. On the contrary, the doctors needed the pupils working with Outdoor patients to care for those in normal labour, whilst filtering out those with problems for medical intervention, and, on the whole, both doctors and directors expressed their appreciation of this.

However, much recent midwifery history has been predicated on a general medical opposition to the practice of midwives. The ERMH material suggests two points. Firstly, the opposition may have come from a defined group within the medical profession - those who stood to lose financially if they lost their private midwifery practice - whilst those doctors who specialised in obstetrics and oversaw charitable dispensaries (like those at the ERMH), saw a much greater use for midwives, at little loss to themselves, and at some gain in skilled identification of problem cases.[4] For them, trained midwives were allies in their attempt to introduced medicalised childbirth to the urban poor. This implies that there is a need for more detailed analysis of the opposition to, and support for, midwives in the nineteenth century.

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[4] A number of books on nineteenth century general practice have emphasised the importance of midwifery to young doctors hoping to establish a practice. (See, for example, Irvine Loudon *Medical Care and the General Practitioner 1750-1850* (Oxford: Clarendon Press, 1986; M. Jeanne Peterson *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978). However, there has been much less examination of the motives of doctors who supported midwifery registration.

This should include the development of maternity dispensaries and charities, the care given by which was frequently mimicked (or taken over) by local authority provision following World War I.

The second point is more nebulous. To a large extent, the examination of midwifery history in the nineteenth century is still dominated by the campaign for registration from 1881 onwards, and the campaigners' conviction that midwifery practice in Britain was moribund. However, the ERMH material furnishes a small amount of evidence that some reform in midwifery training took place at the hospital in about 1870, at much the same period that a similar local training was introduced in Sheffield, and that the London Obstetrical Society started to examine female midwives. In each instance these reforms resulted from the interest of medical men. This suggests that a distinction can be made between midwifery reform, which may have had a far longer but under-stated history, and be linked to changes in understanding and approach to childbirth by the medical profession, and the plans for registration indicating a separate profession. This deserves further investigation.

Although it has not been addressed separately, the aim of this thesis has been to examine the connection between the medicalisation of childbirth, and the development of the hospital itself, including its dispensaries. Like its staff and patients, the ERMH was also subject to major change in the period studied. From its inception it had a dual function: to provide shelter in late pregnancy and at delivery for women who had no other accommodation, and complied with the requirements for admission, and to provide practical experience of childbirth for both male and female pupils. In addition it provided Outdoor attendance at delivery in the patient's home. Thus it had three, sometimes conflicting, duties of care: to its inmates and clients; to its pupils, whose fees comprised approximately a third of its income in the early years; and to the subscribers who supported it.

In direct contrast to the late twentieth century, the Outdoor provision was perceived as a much more conventional area than the Hospital in which to practise midwifery, and in which to introduce reform. Although, in terms of number of patients, it was a

much larger operation, the dispensary apparently attracted much less contemporary comment, possibly because its patients required its services on the grounds of poverty alone. As has been shown in Chapter 3, from 1870 the dispensary patients resembled the parturient population as a whole in terms of age, and by 1890 in terms of marital status also. Again conforming to the practice of the great majority of labouring women, they were seen and delivered in their own homes, with their choice (or, at least, not the hospital's choice) of companions. As conventional maternity patients, dramatic references to them, their need for effective medical care and their suitability as objects of charity, could be, and were made in fundraising appeals in the 1880s and after.

The Outdoor cases provide evidence of changing educational as well as medical practice. It can be argued that dispensary patients were attended principally by medical students because their normality provided an experience similar to that of general practice, although this motive is weakened after 1881, when the Hospital also wished to control the presence and number of students within the building. By 1890 the number and nature of the attendants had increased, so that a much greater number of medical students each attended a far smaller number of cases; by 1912 Outdoor cases were primarily under the care of pupil midwives (Chapter 5). Above all, the social conformity of the dispensary population serves to confirm the reality of the changes in attitudes to childbirth in Edinburgh by both hospital and patients. The Outdoor patients make it evident that by 1912 it was widely accepted that normal childbirth at home was closely monitored post-delivery with regard to rest and infection, whilst the increase in nurses attending in 1890 may also indicate professional nursing care. Although in 1890 emergency admission was seldom accepted by patients and their families, by 1912 Outdoor patients were prepared to be admitted if necessary. For them, birth had become dominated by medical requirements.

The development of Indoor care was much more problematic, and can be measured in various ways: the social change in patients, the developments in the medical establishment, and the hospital's relationship with the community. The hospital's

original function was widely interpreted as being the provision of shelter, rather than medical care, to destitute women whose sole preparation for delivery was acquiring a subscriber's ticket. The analysis of the Indoor patients in Chapter 3 shows that until after 1890 the great majority of inmates were single, with few obviously in search of medical help. This usage of the hospital was certainly recognised by contemporary medical staff, whilst public recognition of this function may well have added to reluctance to be admitted when this was considered necessary for medical reasons. It was certainly believed to affect adversely the appeal of the hospital as a charity. By 1912 there had been considerable change. Numerically, the number of single patients had remained much the same, but the hospital now had an approximately equal number of married patients, many admitted because of medical problems. This also predisposed to a wider social spread. The casebooks no longer provide evidence of refusal to be admitted, although some delays in admission continued. This change in use of the hospital indicates a considerable change in the attitude towards it of both the public as a whole, and of general practitioners, who now recognised it as a resource when they found themselves out of their depth. The implication is that, by 1912, birth was seen as a medical event, and the hospital formed, at least in part, a resource for treatment in the event of problems.

However, changes in the medical establishment at the ERMH chronologically preceded the social change in the patients by almost a generation. As has been shown in Chapter 5, from late 1870 the four ordinary physicians took responsibility for the hospital for three months at a time, and from this period increased their interest in the hospital. They may also have adopted titles used in general hospitals at this time. Approximately ten years later the medical cover was extended by also having an assistant physician, who eventually also worked quarterly, and by the end of the century it was openly recognised that it was the ordinary physician who personally selected the house surgeon who would be senior in his quarter. In the development of such teams the ERMH doctors can be seen as mimicking the 'firms' of their colleagues in the Royal Infirmary, creating a subset of doctors primarily loyal to their chief through his patronage. This was a very visible attempt to model the maternity hospital into a pre-existing general hospital pattern. Thus, by 1912, it can be

concluded that the hospital played a prominent part in its doctors' careers, and can be seen as having become the theatre in which senior doctors appeared, to carry out new treatments, advise their juniors, dispense patronage, and teach. As has been shown in Chapters 4 and 5, this can be directly associated with the increasingly active treatment of patients recorded in 1890 and after, and with the expansion of medical education in Edinburgh. However, it does not relate directly to the acceptance of the hospital by the patients, which appears to have begun to develop in the early years of the twentieth century, rather than the last quarter of the nineteenth.

With the increase in hospital status among senior doctors went increasing stratification of the roles and expectations of junior doctors, students and midwives, the latter in particular becoming responsible for natural labour and all nursing care before and after delivery. However, this aspect of medicalisation apparently altered the relationship between professionals and patients. The tone of the records became more patronising, with the implication that the professionals now believed they knew more about pregnancy and birth than did their patients, and placed less value on patients' perception of their circumstances. There could therefore be a divergence in their aims, notably with regard to post-mortem delivery or examination.

The change in the hospital from a principally social charity, to one able to provide all necessary maternity care, can also be observed in its Annual Reports. Until the early twentieth century, from their content, these emphasised the hospital's social aspect. They continued to focus on the work of the Biblewoman and the Ladies' Committee, and on stories of reconciliation or employment as wetnurses for its inmates, whilst showing unease at the rise in maternal mortality resulting from an increasing number of patients being admitted for medical help when already moribund. Nonetheless, the Reports, which from 1900 include regular lists of donors and collectors, also imply that as the hospital adopted a more openly medical role it became both a more acceptable recipient of individual charity and a cause to which women, in particular, could contribute. Although it is apparent that it was re-defined, the ERMH's charitable function continued to be significant, particularly in its relationships with other, newer, maternity charities. Because this thesis has been primarily based on

casebook analysis it has inevitably not been able to capture all aspects of the relationship between the ERMH and the Edinburgh community. However, research strongly suggests that this would be a fruitful subject for further investigation.

Modern feminist interpretations of the medicalisation of childbirth (that is, the replacement of social by medical priorities during labour, delivery, and the puerperium), have seen it as an imposition placed on patients by an expanding and protectionist medical profession, to the detriment of natural childbirth, and of patients' original female attendants, or midwives. The nineteenth century in particular has been seen as a period in which developing medical technology was applied to childbirth enthusiastically, but ineptly and without consideration for the patient. However, the evidence from the ERMH casebooks presented in this thesis suggests that this is too simplistic a view. By demonstrating genuine negotiation between patients and professionals, it challenges the theory that changes in maternity care were simply imposed upon patients, and suggests a role for patient acceptance in the increased medicalisation of childbirth.

Further, it has also been shown that the degree of medicalisation in place at the ERMH and in its dispensaries by 1914 was in many ways dependent on the assumption that birth itself was a normal physiological process, and that the majority of births would be natural, requiring no intervention from attendants. Whilst the patient care given by hospital staff undoubtedly became more dictatorial, it appears to have been driven by the desire to reduce infection and aid recovery. The principal givers of such care were the pupil midwives. Indeed, the ERMH data implies that trained midwifery benefited from clearer definition of its role, and from increasing interest in the outcome of birth among the poor.

Nonetheless, there was a genuine increase in intervention over the period studied, and use was made of advances in anaesthesia and surgery. Further, the ERMH evidence suggests that this was a real change in the management by doctors of protracted labour. However, detailed analysis of the casebooks shows that such intervention was made only after conclusive evidence of problems was obtained. In

addition, the use of whole year surveys places the increasing number of such cases in the context of a hospital that was slowly earning a reputation as a source of obstetric expertise, and had a growing number of emergency admissions.

In focusing on the years 1844-1914, this thesis has examined a period of transition in attitudes to childbirth in Scotland. By concentrating on a maternity hospital and its outdoor provision, not as an institution, but in terms of the light its records and development cast on childbirth during the period, it has been possible to relate that transition to changing social and medical circumstances in both staff and patients. This has enabled the gradual medicalisation of childbirth to be seen in relation to the professionalisation of both doctors and midwives, and to the apparent wishes of patients.

Appendix 1

Data Collected From Edinburgh Royal Maternity Hospital Registers of Births, Indoor, Outdoor, and Special and Ordinary Casebooks

The table on the following sheets shows the data collected from the Edinburgh Royal Maternity Hospital Registers of Births, Indoor, Outdoor, and Special and Ordinary Casebooks, over the whole years 1850, 1870, 1890, and 1912. The table incorporates comments on the treatment and manipulation of the material collected.

Key to Symbols:

R Item regularly recorded, or recorded if anything to report (e.g. problem at delivery).

(r) Item occasionally recorded.

D Item deduced.

- Item not recorded.

	Indoor Casebooks				Outdoor Casebooks				Leith	Births Registers				Special and Ordinary Casebooks (Selected Cases only)			Comments
	1850	1870	1890	1912	1850	1870	1890	1912	1912	1850	1870	1890	1912	1870	1890	1912	
Casebook Number	**R**	**R**	**R**	**R**	**R**	**(r)**	**R**	**R**	**R**	-	-	-	-	**(r)**	-	-	Recorded in database as described in the casebooks. All database entries (cases) also given individual number
Name	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	Recorded in database as described in the casebooks.
Age	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	Recorded in database as described in the casebooks.
Parity	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	**R**	**R**	**R**	Recorded Indoors as previous births plus miscarriages, and Outdoors as number of pregnancy (gravida).
Date of Delivery	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	**R**	**R**	**R**	Converted for calculation purposes to number of days from beginning of year.
Type of Labour	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	**R**	**R**	**R**	Classified Indoors throughout the period into 'Natural', 'Laborious', 'Preternatural' and 'Complex'. Classified Outdoors in 1912 as' Natural' or 'Tedious'.
Presentation & Position	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	**R**	**R**	**R**	In 1850 and 1870 classified as presenting part in 1st, 2nd or 3rd position in pelvis; in 1890 and 1890 given as presenting part to right or left, anterior, lateral or posterior in pelvis.
Antenatal Problems	**(r)**	**(r)**	**(r)**	**(r)**	-	-	**(r)**	**(r)**	**R**	-	-	-	-	**R**	**R**	**R**	Recorded in database when entered in the casebooks.
Type of Delivery	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	**R**	**R**	**R**	Instrumental or manipulative deliveries are recorded as such in the source, but normal (spontaneous) deliveries are typically inferred from the lack of comment.

Delivery Problems	R	R	R	R	R	R	R	R	R	-	-	-	-	R	R	R	Recorded in database when entered in the casebooks.
Chloral	-	(r)	(r)	(r)	-	(r)	(r)	-	-	-	-	-	-	R	R	R	Recorded in database when entered in the casebooks.
Chloroform	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	R	-	-	-	-	R	R	R	Recorded in database when entered in the casebooks.
3rd Stage Problems	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	-	-	-	-	(r)	(r)	(r)	Recorded in database when entered in the casebooks.
3rd Stage Treatment	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	-	-	-	-	(r)	(r)	(r)	Recorded in database when entered in the casebooks.
Postnatal Problems	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	-	-	-	-	-	-	-	Recorded in database when entered in the casebooks.
Sutures Recorded	-	-	(r)	R	-	-	-	R	R	-	-	-	-	-	-	-	Recorded in database when entered in the casebooks.
Previous Tears	-	-	(r)	R	-	-	(r)	R	R	-	-	-	-	-	-	-	Recorded in database when entered in the casebooks.
Duration 1st stage	R	R	R	R	-	-	-	(r)	(r)	-	-	-	-	-	-	-	Converted to minutes for calculation purposes.
Duration 2nd stage	R	R	R	R	-	-	-	(r)	(r)	-	-	-	-	-	-	-	Converted to minutes for calculation purposes.
Duration 3rd stage	R	R	R	R	-	-	-	(r)	(r)	-	-	-	-	-	-	-	Converted to minutes for calculation purposes.
Total Labour Time	R	R	R	R	-	-	-	R	R	-	-	-	-	-	-	-	Converted to minutes for calculation purposes.
Health of Mother on Discharge	R	R	R	R	R	R	R	R	R	-	-	-	-	R	R	R	Recorded throughout as 'well' on discharge Indoors, and as such in 1912 Outdoor casebooks. In Leith this information was extracted from the greater detail available from Leith Branch casebook.
Sex of Child	R	R	R	R	R	R	R	R	R	-	-	-	-	(r)	(r)	(r)	Recorded in database as described in the casebooks.
Comments on Child	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	(r)	-	-	-	-	(r)	(r)	(r)	Recorded in database when entered in the casebooks.
Child's Condition at Birth	R	R	R	R	R	R	R	R	R	-	-	-	-	R	R	R	Recorded as 'alive', 'dead' or 'putrid' in Indoor and Outdoor casebooks, and as 'healthy', 'delicate', or 'dead' in 1912 Students' external casebooks.

Child's Condition on Discharge	R	R	R	R	R	R	R	R	R	-	-	-	-	-	-	-	Recorded as 'well', 'dead' or 'weakly' in all casebooks.
Prematurity	(r)	(r)	(r)	R	(r)	(r)	(r)	R	R	-	-	-	-	(r)	(r)	(r)	Specific comment apparently made on this in 1912.
Baby Weight	R	R	R	R	-	-	-	-	-	-	-	-	-	-	-	-	Converted to ounces for calculation purposes.
Delivered by	R	R	R	R	R	R	R	R	R	-	-	-	-	-	-	-	Individual's name as recorded in casebook.
Status of person delivering	R	R	R	R	R	R	R	R	R	-	-	-	-	-	-	-	Coded as house surgeon ('hs'), based on non-casebook evidence of post, senior doctor ('dr'), similarly deduced, professor ('prof'), by name, and midwife,('mw'), based on casebook or Nurses' Register evidence of post.
Present	R	R	R	R	R	R	R	R	R	-	-	-	-	-	-	-	Individual's name as recorded in casebook. (Recorded for up to five witnesses)
Status of each witness	R	R	R	R	R	R	R	R	R	-	-	-	-	-	-	-	Coded as house surgeon ('hs'), based on non-casebook evidence of post, senior doctor ('dr'), similarly deduced, professor ('prof'), by name, and midwife('mw'), based on casebook or Nurses' register evidence of post. (for each witness)
Antenatal Stay	-	-	-	-	-	-	-	-	-	(r)	(r)	-	-	(r)	(r)	(r)	Deduced from dates of admission, delivery, and demission, when recorded.
Postnatal Stay	-	-	-	-	-	-	-	-	-	(r)	(r)	-	-	(r)	(r)	(r)	Deduced from dates of admission, delivery, and demission, when recorded.
Total Stay	-	-	-	-	-	-	-	-	-	(r)	(r)	-	-	(r)	(r)	(r)	Deduced from dates of admission and demission, when recorded.
Postnatal Care Days 1-10	-	-	-	-	-	-	-	R	R	-	-	-	-	(r)	(r)	(r)	Recorded in database as described in the casebooks.
Postnatal Problem for Mother	(r)	(r)	(r)	(r)	(r)	(r)	(r)	R	R	-	-	-	-	(r)	(r)	(r)	Recorded in database as described in the casebooks.
Postnatal Problem for Child	(r)	(r)	(r)	(r)	(r)	(r)	(r)	R	R	-	-	-	-	(r)	(r)	(r)	Recorded in database as described in the casebooks.
Medicine given	-	-	-	-	-	-	-	R	R	-	-	-	-	R	R	R	Recorded in database as described in the casebooks.
First Day of Mobilisation	-	-	-	-	-	-	-	(r)	(r)	-	-	-	-	R	R	R	Recorded in database as described in the casebooks.
Doctor Involved in Care Postnatally	-	-	-	-	-	-	-	R	R	-	-	-	-	R	R	R	Recorded in database as described in the casebooks.
Maternal Mortality/Morbidity not	(r)	(r)	(r)	(r)	(r)	(r)	(r)	R	R	-	-	-	-	R	R	R	Recorded in database as described in the

Associated with Childbirth																	casebooks.
Mother's Last Parish of Residence	-	-	-	-	-	-	-	-	-	R	R	R	R	-	-	-	Recorded as appears in Births Register, then coded into Edinburgh, Leith, Edinburgh suburbs, Scotland outwith Edinburgh, England and Wales, Ireland, and outwith Great Britain.
Mother's Birthplace	-	-	-	-	-	-	-	-	-	R	R	R	R	-	-	-	Recorded as appears in Births Register, then coded into Edinburgh, Leith, Edinburgh suburbs, Scotland outwith Edinburgh, England and Wales, Ireland, and outwith Great Britain.
Number in Birth Register	-	-	-	-	-	-	-	-	-	R	-	R	R	-	-	-	Recorded in database as entered in the Births Register.
Married/Single/Widowed	-	-	-	-	D	D	D	D	D	R	R	D	D	-	-	-	Indoors, recorded outright until 1877, then deduced from presence of husband's name and occupation. Outdoors, deduced from use of title or not in Casebook.
Date of Marriage	-	-	-	-	-	-	-	-	-	-	-	R	R	-	-	-	Recorded in database as entered in the Births Register.
Mother's Father's Occupation	-	-	-	-	-	-	-	-	-	R	R	-	-	-	-	-	Recorded in database as entered in the Births Register.
Mother's Father's Occupation Classified by 1881 Census	-	-	-	-	-	-	-	-	-	R	R	R	R	-	-	-	Occupation classified according to General Record Office Census of England and Wales, 1881: Instructions to the Clerks Employed in Classifying the Occupations and Ages of the People
Mother's Father Deceased before Admission to ERMH	-	-	-	-	-	-	-	-	-	R	R	-	-	-	-	-	Recorded in database as entered in the Births Register.
Mother's Occupation	-	-	-	-	-	-	-	-	-	-	-	R	R	-	-	-	Recorded in database as entered in the Births Register, for single women only
Mother's Occupation Classified by 1881 Census	-	-	-	-	-	-	-	-	-	-	-	R	R	-	-	-	Occupation classified according to General Record Office Census of England and Wales, 1881: Instructions to the Clerks Employed in Classifying the Occupations and Ages of the People
Child's Father's Name	-	-	-	-	-	-	-	-	-	R	R	R	R	-	-	-	Recorded in almost all cases until 1877, then only recorded if mother married.
Child's Father's Occupation	-	-	-	-	-	-	-	-	-	R	R	R	R	-	-	-	Recorded in almost all cases until 1877, then only recorded if mother married.

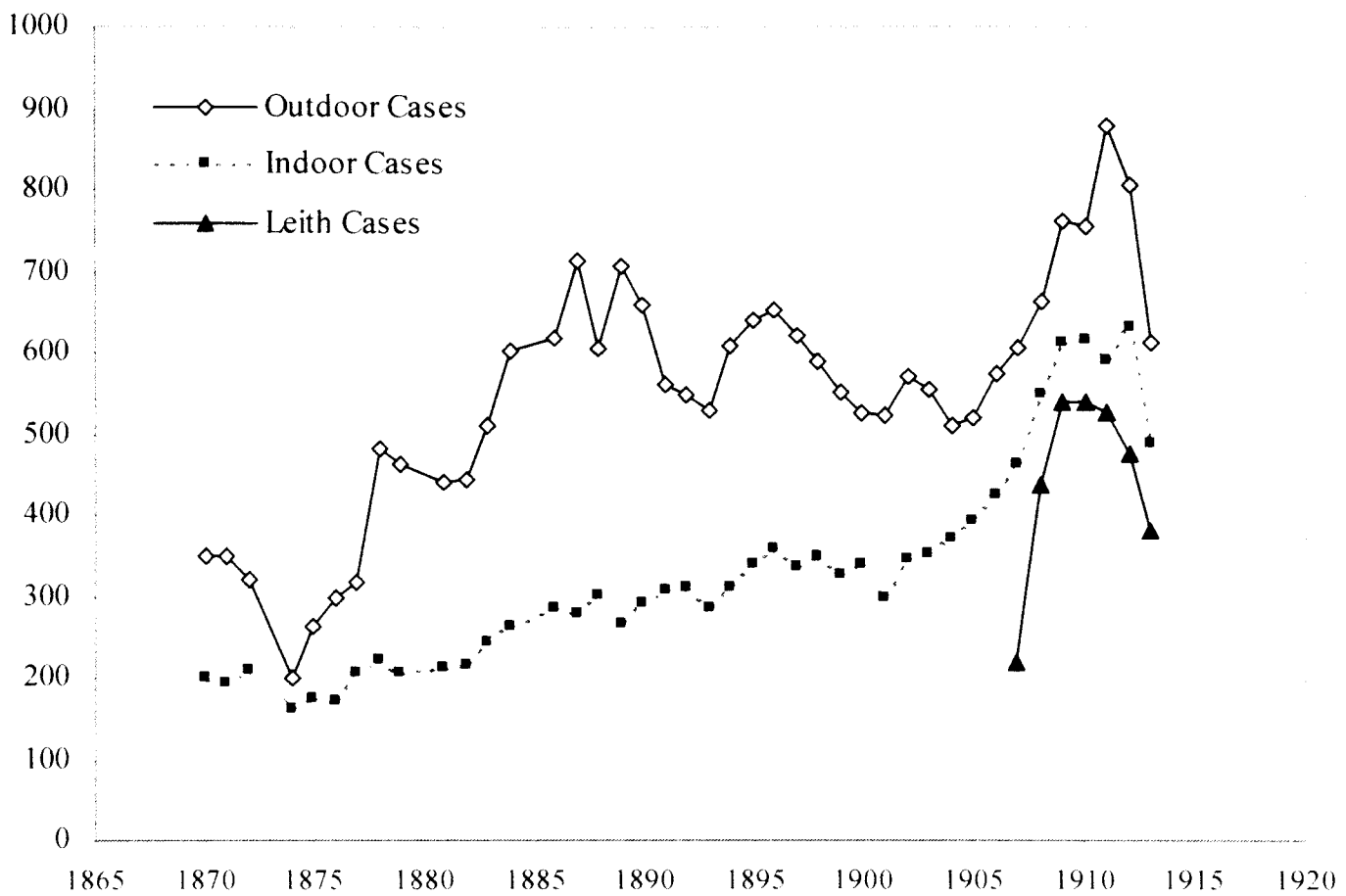
Child's Father's Occupation Classified by 1881 Census	-	-	-	-	-	-	-	-	-	**R**	**R**	**R**	**R**	-	-	-	Occupation classified according to General Record Office Census of England and Wales, 1881: Instructions to the Clerks Employed in Classifying the Occupations and Ages of the People
Child's Father Alive/Dead	-	-	-	-	-	-	-	-	-	**R**	**R**	**R**	**R**	-	-	-	Until 1877, recorded in database as entered in the Births Register: after then rarely recorded, for married women only.
Child's Father's Present Residence	-	-	-	-	-	-	-	-	-	**R**	**R**	**R**	**R**	-	-	-	Recorded as in Register, coded into Edinburgh, Leith, Edinburgh suburbs, Scotland outwith Edinburgh, England and Wales, Ireland, and outwith Great Britain.
Mother's Future Residence	-	-	-	-	-	-	-	-	-	-	-	**R**	-	-	-	-	Recorded as in Register, coded into Edinburgh, Leith, Edinburgh suburbs, Scotland outwith Edinburgh, England and Wales, Ireland, and outwith Great Britain.
Literacy	-	-	-	-	-	-	-	-	-	**R**	-	-	-	-	-	-	Recorded in Births Register until August 1861.
Remarks	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	**R**	-	-	-	-	-	-	-	Recorded in database verbatim as transcribed from the casebooks.

Appendix 2
Number of Indoor and Outdoor Cases from ERMH Annual Reports

Annual Report No.	Year published	Indoor Cases	Outdoor cases	Maternal Deaths
26	1871	223		1
26	1871	199	349	Not Recorded
27	1872	193	350	1
28	1873	210	320	1
30	1875	161	199	2
31	1876	175	263	2
32	1877	171	298	1
34	1879	206	318	Not Recorded
34	1879	222	482	Not Recorded
35	1880	206	464	7
37	1882	213	442	2
38	1883	216	446	4
39	1884	246	510	7
40	1885	263	602	3
42	1887	287	619	1
43	1888	280	714	2
44	1889	302	607	1
45	1890	266	707	5
46	1891	293	661	3
47	1892	307	561	3
48	1893	310	550	Not Recorded
49	1894	285	531	4
50	1895	310	610	Not Recorded
51	1896	340	642	Not Recorded
52	1897	358	654	8
53	1898	338	622	Not Recorded
54	1899	348	590	Not Recorded
55	1900	326	551	Not Recorded
56	1901	340	528	11
57	1902	300	523	Not Recorded
58	1903	347	570	Not Recorded
59	1904	353	556	Not Recorded
61	1906	372	511	Not Recorded
61	1906	395	520	Not Recorded
62	1907	425	* 575	Not Recorded
63	1908	464	825	Not Recorded
64	1909	549	1100	Not Recorded
65	1910	612	1302	18
66	1911	615	1296	Not Recorded
67	1912	591	1407	15
68	1913	633	1282	Not Recorded
69	1914	489	995	Not Recorded

* Leith cases included in Outdoor total from 1907

Figure A2.1 Numbers of Indoor and Outdoor Patients at the ERMH 1870-1913



Source: ERMH Annual Reports, 1870-1913

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